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

Annual Business Plan

2018-19

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

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Transmittal Letter from the LHIN Board Chair

March 1, 2018

Tim Hadwen
Assistant Deputy Minister
Health System Accountability and Performance Division
Ministry of Health and Long-Term Care
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Dear Mr. Hadwen,

The North East Local Health Integration Network (NE LHIN) is pleased to provide you with our Board-approved 2018-2019 Annual Business Plan (ABP).

This ABP encompasses the strategic directions of Patients First Act 2016 and its transformative changes to improve the patient experience. It also focuses on the third 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.

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

We are committed to meeting the priorities in the Minister's Mandate letters and will continue to work with our many partners to improve the patient experience, performance of the system, and health of the population we serve. Evidence of our work to move forward with these key pillars is found throughout the following pages.

This past fall, our senior leadership team engaged with staff, Board, and system partners to ensure our IHSP priorities are aligned with the mandate letters and Patients First. The result is our current Strategic Direction (fall 2017) to, *improve the health of our population by building capacity to increase access to quality integrated care for Northerners, including Francophones and Indigenous people*.

Our levers to build system capacity for Northerners include: championing digital health technologies, including patients in our decision making, holding ourselves and our health service providers accountable, focusing on population health and equity, and working in partnership with patients, providers and community residents.

With the successful transition of the NE CCAC to the NE LHIN on May 31, 2017, this ABP now looks to our second year of bringing together all home and community care providers into one sector with a single access point and a standardized referral process to improve navigation for patients. We are working with home and community care providers to implement our One Client, One Plan project, which will deliver a consistent approach to care planning with clients and families.

We have implemented a focused approach in our sub-region planning that includes 'Care Communities' for the purposes of primary care planning. Our extensive engagement over the past several years have informed our work to advance our sub-region priority to deliver more integrated and patient-focused home and community care, primary care, and mental health and addictions care. This includes embedding care coordinators in primary care settings.

We have strengthened the involvement of Northerners through our 18-member Patient and Family Advisory Committee which met for the first time in the fall of 2017. Patient Advisors are now engaged in our LHIN's work at both a regional and sub-region level and are paramount in helping us strengthen the Northeastern Ontario health care system.

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

R.M. (Ron) Farrell, Chair, NE LHIN Board of Directors

NE LHIN Organizational Values

People

People are what really matter. Our health care system is **people caring for people**. We include patients, families, caregivers, health service providers, community partners and employees in our decision-making. We **value** and **respect** their input.

Trust

We recognize that **trust** built on **relationships** of **integrity** and **respect** are foundational in caring for **people** and **connecting** the health care system for everyone.

Caring

We believe that health care is about **caring** for people with a **human touch**.
We support and empower **patients and their families** in collaborating with providers and taking ownership of their **personal care plan.**
We believe a care plan must respect an individual's **cultural and linguistic needs** and honour their **heritage**.

Collaborative

We unite under a common vision and purpose that enables us to maximize **each other's contributions** to a system of care that is focused on **improving the health of our population, including Francophone and Indigenous people.**

Responsible

We hold ourselves **accountable** to make **transparent decisions** based on **health equity, best practices, and patient safety** that contribute to a high **quality, integrated, safe** and **fiscally responsible** health care system.

Innovative

We believe in building a **safe environment** to embrace opportunities to **improve patient care** and **connect** all parts of the local health care system in creative and meaningful ways.

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.

This plan reflects work the NE LHIN will undertake in 2018/19 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.

This ABP is aligned with the priorities outlined in the 2018/19 Minister's Mandate Letter as well as the key components of the 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
- Improved health equity and reduced health disparities

This past year, we refreshed our strategic direction, based on transformational work across the system, the direction from the Ministry of Health and Long-Term Care, and our own IHSP priorities (See diagram page 6).

Strategic Direction for 2018/2019: IMPROVE POPULATION HEALTH BY BUILDING CAPACITY

While we remain focused on the full continuum of care, our areas of focus to improve the health of our population by building capacity to increase access to quality integrated care for Northerners will include: home and community care; primary care and mental health and addictions.

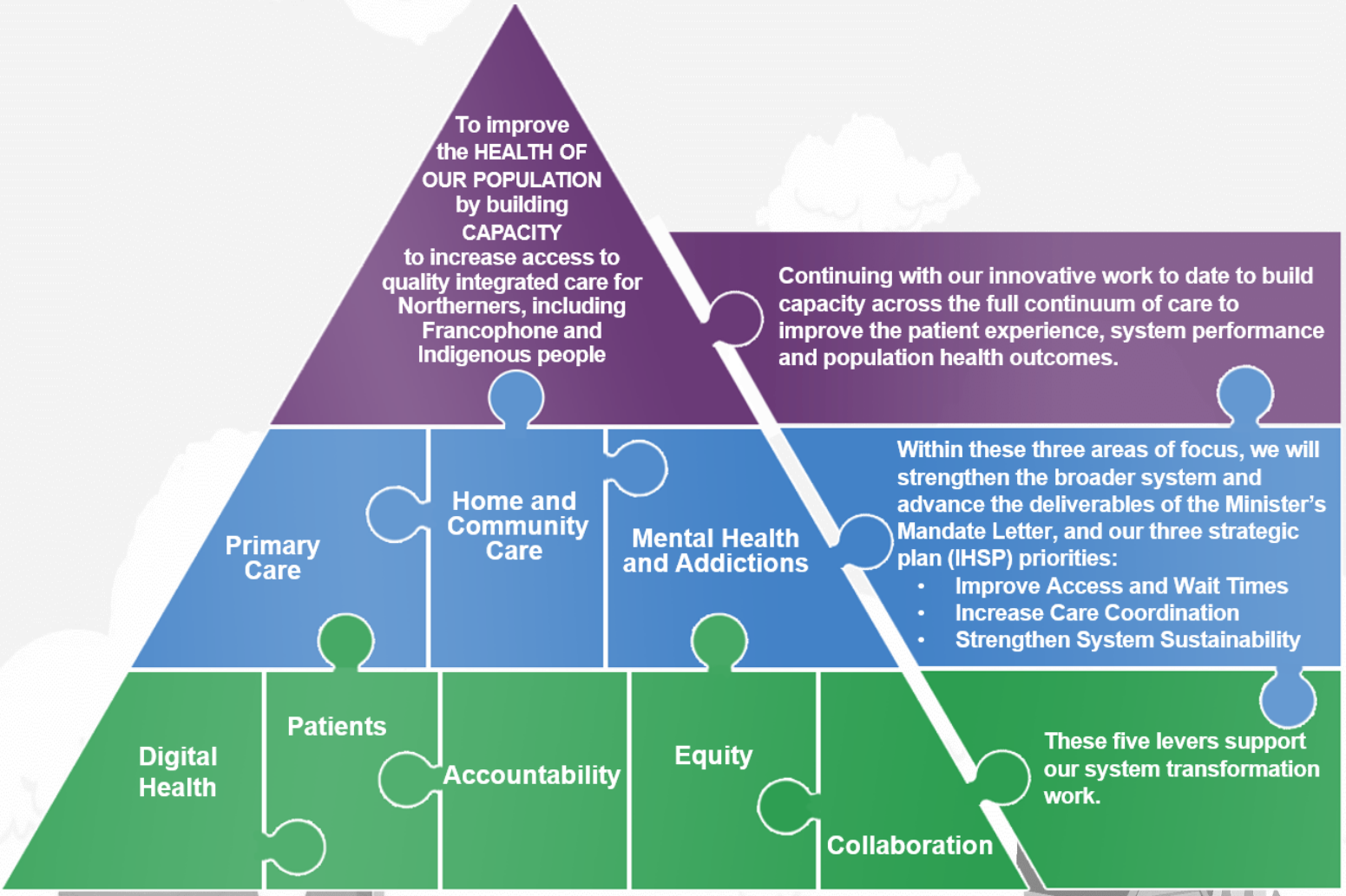
We will continue to move forward with system transformation in other areas of the health care system to improve patient flow in acute care, long-term care, and all sectors. Our **levers** to build system **capacity** for Northerners are:

- championing **digital health** technologies
- including **patients** in our decision making
- holding ourselves and our health service providers **accountable**
- focusing on **population health** and **equity**
- working in **partnership** with patients, providers, and community residents

Performance Measurement

This annual business plan will be monitored through our Ministry-LHIN Accountability Agreement performance indicators, customer service and client complaints measures, quality standards, and the specific measures outlined within this plan to monitor implementation of the identified priorities.

Our 2018-2019 Strategic Direction



Measuring our Success

- MLAA Indicators
- Annual Business Plan
- Patient and Family Advisory Committee

North East LHIN Priority Alignment

Provincial Over-Arching Action Plan

Patients First: 4 Provincial Strategic Directions

Patient Experience | Access | Integration | Health Equity

North East 3-Year Plan

IHSP Priorities: 3 North East Strategic Directions

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

Renewed Strategic Direction (2018)

To improve the health of our population by building capacity to increase access to quality integrated care for Northerners, including Francophone and Indigenous people

Ministry-LHIN Collective Priorities (2017-18) 1-Year Plan

Minister's Mandate Letter: 6 Areas of Focus

- Improve the Patient Experience
- Address root causes of health inequities
- Improve access to primary care & reduce wait times for specialist care, mental health and addictions, home and community, acute care
- Break down silos between sectors and providers to ensure seamless transitions for patients
- Support innovation by delivering new models of care and digital solutions
- Reduce the burden of disease and chronic illness and invest in health promotion

Quarterly

Concrete Local PRIORITIES

1. Capacity
   - *Sub-Regions/Care Communities*
   - *Alternate Level of Care (ALC)*
   - *Integration (Internal/External)*
   - *Transportation*
   - *Long-Term Care*
   - *Population Health Strategies*
   - *Standardized Rehab Care*
   - *Dementia/BSO*
   - *Continuous Quality Improvement*
2. Mental Health and Addictions
3. Home and Community Care
4. Primary Care
5. Digital Health
6. French Language Services
7. Indigenous Health

Annual Business Plan

Quarterly

Community Level Plans (Develop a plan for each priority *(quarterly reporting placemat)*

Quarterly Reported; Frontline; SLT: Board

Measurable Indicators: NE LHIN Performance and Quality Scorecard

Desired Outcomes: Improved Patient Experience, System Performance, Population Health

NE LHIN Alignment with the Priorities of the Minister's Mandate Letter

Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP

Transparency and Public Accountability	• Effectively manage all operational and strategic risks through the implementation of an Integrated Risk Management (IRM) Framework.
	• Work with Health Shared Services Ontario (HSSOntario) to complete an enterprise-wide review of LHINs that identifies opportunities for improving efficiency and effectiveness, and savings that can be reinvested into patient care.
	• Improve accountability and transparency of the NE LHIN and its funded providers.
	• Collaborate with the Ministry to review/improve key accountability instruments, tools and related processes:
	  ○ Annual Business Plan
	  ○ Ministry-LHIN Accountability Agreement (MLAA indicators)

Improve the Patient Experience	• Engage the NE LHIN Patient and Family Advisory Committee (PFAC) to ensure patients and families are involved in NE LHIN decision-making. • Hold quarterly PFAC meetings. • Develop PFAC priorities and work plan. • Align members of PFAC to be involved in LHIN initiatives. • Integrate patient stories and storytelling into LHIN work to demonstrate the desired future state of health care service delivery across the NE LHIN. • Standardize complaints process. • Acknowledge complaints within two days; address complaints within thirty days. • Improve specificity of the Client and Caregiver Experience Evaluation survey results to enable sub-region analyses.

Build Healthy Communities Informed by Population Health Planning	• Support development of a Sub-Region / Care Communities* Strategy.
	• Classify data by sub-regions / communities to inform quality improvement initiatives.
	• Socialize the concept that care communities are a network of health and social service providers working together to integrate care for patients.
	• Develop outcome-focused action plans that are aligned with Patients First.
	• Formalize relationship with public health including:
	  ○ Population health approach that is integrated with local planning and service delivery across the continuum of health care
	  ○ Health services responsive to population health needs and promote health and health equity
	  ○ Better connected health promotion, health protection and health care

Quality Improvement, Consistency and Outcome-Based Delivery	• Ensure availability of quality health care services when people need them. • Implement the Regional Quality Table's Integrated Regional Quality Plan. • In collaboration with Health Quality Ontario, increase capacity for quality improvement and support our health service provides through the development and implementation of quality standards. • Support health service providers to develop and implement Quality Standards. • Improve patient transitions from hospital through improved discharge follow up.
Equity	• Work in partnership to improve health equity across the region by building on the Northern Ontario Health Equity Strategy and the collective work of the regions five public health units, the LHIN and Health Quality Ontario. • Build cultural competency amongst Health Service Providers and system partners to reduce barriers and improve access to equitable care that supports diverse populations, including Francophone and Indigenous Northerners.

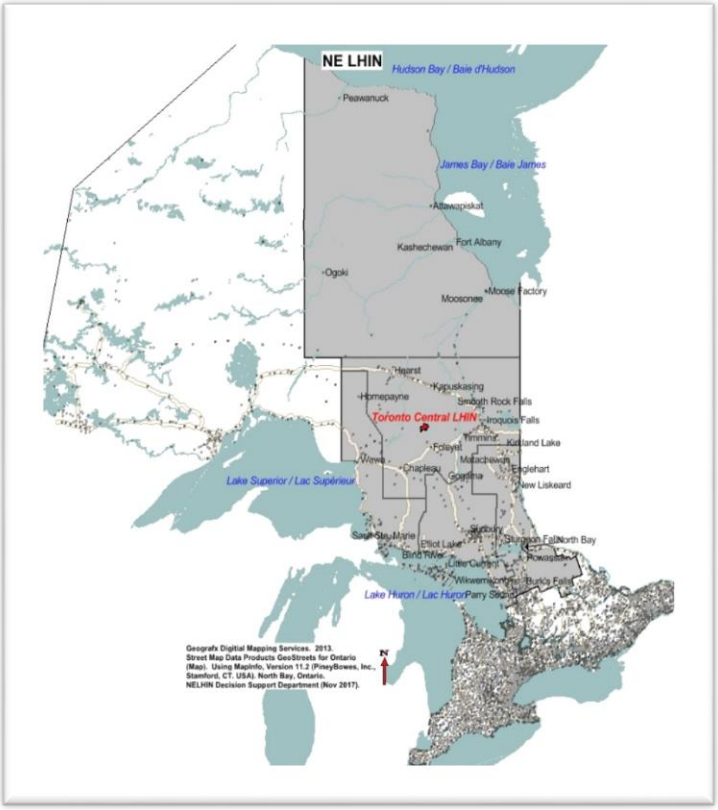
Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
	Francophone Northerners • Identify patient journey gaps. • Increase number of organizations providing Active Offer by 50%. • Support three additional HSPs to submit designation plan. • Collaborate with the Réseau du mieux-être francophone du Nord de l'Ontario to ensure continued compliance with FLS Act. **Indigenous Northerners** • Identify patient journey gaps • Support providers to provide care in a culturally sensitive manner • Collaborate with federal and provincial partners • Ensure quality data collection • Support Local Aboriginal Health Committee in implementing the ***NE LHIN Aboriginal Health Care Reconciliation Action Plan***.
Primary Care	• Improve access to and reduce wait times for: primary care, specialist care, mental health and addictions, home and community care, acute care • Support Health Human Resource Capacity planning with care communities. • Improve access to inter-professional teams. • Spread and scale Health Links approach. • Embed Home and Community Care care coordinators in primary care settings. • Improve patient transitions from hospital through improved discharge follow-up. • Improve adoption of eHealth solutions for secure communications between primary care and other providers.
Hospital and Partners	• Expand the NE Patient Flow / Alternate Level of Care (ALC) Strategy. • Continue improvements in stroke care. • Continue implementation and evaluate rural health strategy. • Continue implementation of Quality-Based Procedures (QBPs). • Continue implementation of Bundled Care.
Specialist Care	• Work on surge capacity planning and readiness to ensure ED patient flow. • Continue to implement LHIN CEO Council's five recommendations to improve access to appropriate medical imaging. • Transform Musculoskeletal (MSK) care. Engage clinicians in conversations on MSK models of care to identify leaders and champions. • Assemble a local implementation team to inform planning and address clinical practice change, information technology and/or performance monitoring needs.
Home and Community Care	With input from patients, caregivers, and partners the overarching effort will be to continue to implement the initiatives in ***Patients First: A Roadmap to Strengthen Home and Community Care***. Specific goals include: • Implement One Client, One Plan (OCOP) • Implement collaborative service delivery models for HCC • Coordinate End of Life / Primary Care • Embed Care Coordinators into Primary Care settings • Implement Levels of Care Framework • Implement Family-Managed / Self-Directed Care • Implement Wound Care Quality Standards

Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
Long-Term Care	• Engage with long-term care operators to help increase capacity in areas of our region that are impacted by Alternate Level of Care (ALC). • Identify long-term care operators/partners to incorporate short-stay services. • Enhance opportunities for short stay convalescent care and respite beds.
Dementia Care	• Implement Provincial and NE LHIN Dementia strategy. • Complete analysis of current Behavioural Supports Ontario (BSO) resources as well as a three year plan to ensure resources are shared equitably across the region. • Develop local capacity plans, leveraging the work of the "Dementia Capacity Planning Project".
Mental Health and Addictions	• Enhance a coordinated client-centered approach to Mental Health and Addictions. • Implement work plan of Regional Mental Health and Addictions Advisory Council. • Align NE LHIN work with Provincial leadership tables. • Train and certify providers to use the standardized addictions assessment tools. • Implement Opioid Strategy. • Increase housing opportunities and supports for people living with mental health and/or addictions.
Innovation, Health Technologies and Digital Health	Support implementation of prioritized initiatives of the 10-point Digital Health Action Plan: • Make care available in more places - continue to support and sustain volumes as well as target how Telemedicine and Telehomecare can enable the NE LHIN to deliver on home and community care; primary care and community care integration. • Make it easier for providers to communicate with one another including implementation of eReferral for the orthopaedic care pathway, expansion of eConsult, eNotification and transition of Physician Office Integration (POI) to Hospital Report Manager (HRM). Maximize value of Hospital Information System (HIS) investments. Continue to implement NE HIS Roadmap aligned with Ministry HIS Renewal Advisory Panel Recommendations. NE will be the first tenants in the Meditech Collaborative HIS Hub.

*__Care communities__ are a local network of health and social service providers working together to integrate care for each person. The NE LHIN is identifying care communities around patients to improve access to health and social services as close to where Northerners live as possible. __Sub-regions__ are geographic areas. The NE LHIN has 5 sub-regions which were created to better understand patient needs at a local level.

Overview of the LHIN's current and forthcoming programs/activities

The NE LHIN is responsible for planning, funding, and integrating health care, as well as delivering home and community care to people across Northeastern Ontario. Our large geography – 400,000 square kilometers – is divided into five sub-region planning areas which helps to ensure localized planning, quality health care delivery, and priority setting.



The North East LHIN manages $1.5 billion in front-line health care. We provide funding to about 150 health service providers across six sectors (some delivering services in more than one sector), including:

- 25 hospitals
- 71 home and community care providers
- 40 long-term care homes
- 44 mental health and addictions service providers
- 6 community health centres

The North East LHIN is also the largest provider of home and community care services in Northeastern Ontario, including the direct provision of therapy services. We deliver care to more than 17,000 Northerners of all ages, and manage eligibility and admissions to long-term care homes, short-stay respite, assisted living, and adult day programs.

Environmental Scan

Accountability

The NE LHIN has 166 agreements that hold Health Service Providers accountable to deliver $1.4 billion in health care annually. These agreements include: 108 Multi Sector Service Accountability Agreements (M-SAAs), 25 Hospital Service Accountability Agreements (H-SAAs), and 33 Long-Term Care Service Accountability Agreements (L-SAAs) covering 40 long-term care homes. In addition, the LHIN delivers home and community care services across the northeast through a direct investment of $143 million.

Geography

The NE LHIN structures its large geographic area (400,000 square kilometres) into five sub-regions to support local planning and integration efforts. The map above shows our sub-region boundaries. A to-scale icon of Toronto Central LHIN has been added to illustrate the vast size of our LHIN. About 60% of the NE LHIN population live in four cities – Greater Sudbury, Sault Ste. Marie, North Bay and Timmins. Approximately 110 smaller communities (200 households or more) are scattered across the region, making it a challenge to provide services close to home for Northerners. NE LHIN staff work out of 20 LHIN offices, 12 hospitals and four family health team offices.

The sub-regions are on average, 80,000 km^2 each and have population scattered across multiple cities, towns and smaller communities. When planning for services close to home it is important to consider transportation and travel times. Four of the five sub-regions take three to six hours to travel across by road and the fifth has multiple communities that are only accessible by air. These areas are too large to be used for "local" planning. Sub-regions must be further broken down into care communities. What might appear to be an acceptable level of resources or services in a sub-region may well be the result of a combination of care communities that individually have too many or too few resources relative to their needs.

Access to Primary Care Health Services

The NE LHIN is home to approximately 538 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.

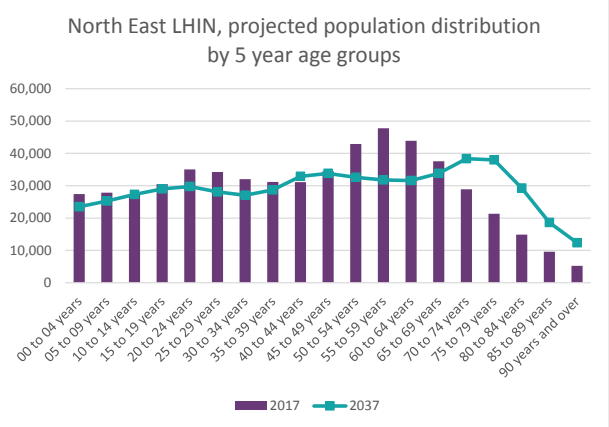
The Health Quality Ontario Health Care Experience Survey shows the NE LHIN with the second lowest attachment rate among LHINs. It is estimated that 9.4% of residents are unattached to a primary care provider. We also have the second lowest rate for percent of adults able to see a primary care provider on the same or next day, 28% and those able to see a primary care provider within 3 days was 45.6%. We have the lowest rate for people whose wait time to appointment was "about right" at 61.9%. This is based on results for the period of July 2016 to June 2017.

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.). The NE LHIN provides home and community care services to more than 17,000. On an annual basis, this adds up to 91,898 home therapy visits, 23,708 school therapy visits, 370,616 nursing visits and more than 1.2 million personal support hours.

The NE LHIN is significantly impacted by the lack of personal support workers and professional therapy providers in Northeastern Ontario. These factors are having an impact on the ability to provide services.

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 2.1% is expected while the proportion of the population age 65 and older is projected to increase from 20.9% to 30.9%. The number of seniors will increase by 44.9% - a demographic shift that will have major implications on the delivery of health care services.

Socio-demographic Characteristics

The NE LHIN has a large Francophone community with 23.2% of residents reporting French as their mother tongue. This is the highest percentage of any LHIN. The Cochrane sub-region has the highest percentage of all sub-regions in the province at 48.5%.

There are about 10.9% of residents who identify as Aboriginal living in the NE LHIN. This is the second highest rate among all LHINs. The James and Hudson Bay Coasts sub-region has the highest rate among sub-regions in the province at 91.7%. The range of results for the other four sub-divisions is 8.2% to 11.3%. Employment and education levels are some of the lowest in the province.

Mortality

The all-cause mortality rate for NE LHIN residents was 929.7 per 100,000, much higher than the Ontario all-cause mortality rate in 2011. This rate was the highest among all the LHINs, and has decreased only slightly (0.2%) since 2007. The leading causes of death in 2011 were ischaemic heart disease, cancer of lung and bronchus, dementia and Alzheimer disease. The top 10 diseases accounted for 55.1% of total resident deaths. Many of the top 10 cause-specific mortality rates for residents of the NE LHIN in 2011 were the highest rates or among the highest rates of all the LHINs. 42.7% of deaths were considered premature in 2011. This was the second highest percentage of premature deaths among all LHINs.

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 indicators 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 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	James and Hudson Bay Coasts
Demographic Highlights					
Population (2015 estimate)	102,000	80,300	144,000	228,000	7,600
People who report French as their mother tongue	5.8%	48.5%	21.4%	23.8%	0.5%
People who identify as Aboriginal	10.8%	9.8%	8.2%	11.3%	91.7%
Seniors Aged 65+	21.0%	17.4%	20.7%	20.0%	6.9%
Seniors Living Alone	28.1%	31.0%	28.9%	27.5%	21.0%
Lone Parent Families	31.9%	26.5%	29.8%	30.1%	42.7%
Children and Youth (0-19)	19.7%	21.8%	19.6%	19.8%	39.0%
Low Income[2]	13.8%	13.1%	15.1%	13.2%	23.1%
Hold Higher Education[3]	61.0%	55.9%	58.7%	62.1%	38.0%
Health Service Provider Highlights					
Health Links[4]	1	2	2	1	0
Hospitals	4	8	6	6	1
Home and Community Providers	15	17	21	31	7
Community Mental Health and Addictions	10	12	8	13	1
Long-Term Care Homes	7	7	12	14	0
Aboriginal Health Access Centres	1	-	-	2	0
Community Health Centres	-	2	2	2	0
Nurse Practitioner-Led Clinics	2	-	1	3	0
Public Health Units	1	2	2	3	1

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 graduating from 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.

Priority #1: Capacity

Priority Description

Health system capacity planning identifies the health care needs of a population, optimizing and aligning the supply of resources and services available to address those needs. The NE LHIN is working to build capacity within communities to better support system transformation.

Goals to improve access and build capacity

1. Support development of **Sub-Region / Care Communities Strategy**
2. Improve patient flow between care settings (**ALC** avoidance / reduction)
3. Support adoption of best practices related to **integration**
4. Enhance **transportation** services so people can get to and from the care they need
5. Support redevelopment of and access to **long-term care homes**
6. Identify **population health strategies** and integration across the continuum of care
7. Increase timely access to standardized **rehab care** and support best practices
8. Enhance **Dementia / Behavioural Support Ontario (BSO)services** for seniors and their caregivers
9. Ensure continuous **quality** health care services.

Current Status

Sub-Region Development/Care Communities Strategy: In January 2017, the Ministry of Health and Long-Term Care endorsed the NE LHIN's five sub-regions. By looking at care patterns through a smaller, more local lens, the NE LHIN is able to better identify care communities that define a network of health and social service providers working together within a geographic area to integrate care for Northerners.

Alternate Level of Care (ALC): ALC focuses on patients who have completed their acute hospital treatment and await the availability of their next care level. The NE LHIN's focus is on building community capacity to support seniors in communities through programming such as assisted living, Telehomecare which provides people with access to a nurse through technology in their home, and PATH (Priority Assistance to Transition Home), which helps older adults transition home after they have been discharged from hospital. The NE LHIN is implementing a Patient Flow Strategy to address common priorities across the region while also addressing unique local needs.

Integration: The NE LHIN continues to support health service providers expressing an interest in integration. As part of this work, the NE LHIN is updating its Integration Strategy and will make it publically available to best support providers. In addition, the NE LHIN will provide education to all stakeholders on the updated strategy.

Non-Urgent Patient Transportation (NUPT): A made-in-the-North solution based on a comprehensive data-driven analysis was put in place to replace EMS-delivered, long-distance, non-urgent transfers in the region and an alternate non-ambulance service. Implementation, beginning with Phase 1 in early 2018, will see a mix of scheduled and on-demand NUPT capacity in and around the Sudbury and Timmins Hub centres.

Long Term Care Home (LTCH) Renewal: All eligible LTCH operators are engaged to increase capacity in areas of our region that are impacted by Alternate Level of Care (ALC), so as to better manage the supply of permanent beds and decrease waitlists. An analysis of need is underway and will continue over the next three years as LTCHs begin redevelopment. A review of short stay respite beds to identify opportunities to relocate beds to areas with identified needs was also complete.

Population Health: The NE LHIN will continue its work to improve health equity across the region by building on the Northern Ontario Health Equity Strategy and the collective work of the regions five public health units, the LHIN and Health Quality Ontario. We will formalize collaboration between the NE LHIN and the five public health units by

identifying common population health priorities and opportunities. Through a renewed agreement between the five public health units, we will continue to implement across the region the falls prevention best practices; stay on your feet (SOYF). Using the "balance of care" methodology, a number of housing capacity scenarios have been developed based on varying levels of diversion of seniors from long-term care to assisted living. The first of its kind in Ontario, the NE LHIN Housing report models scenarios at the LHIN, sub-region and community levels and will continue to guide out work.

Rehabilitation Care: A region-wide capacity planning exercise guided by the Rehabilitative Care Alliance Framework is underway for all groups that could benefit from bedded levels of rehabilitative care. A LHIN-led Steering Committee has been established to guide the work. The capacity plan will analyze all bedded rehabilitative care programs and community-based rehabilitation programs. The final report will present capacity plans and include a user model that allows real time updating and theoretical modeling.

Dementia/Behavioural Supports Ontario (BSO) Services: Analysis of current BSO resources as well as a three year plan is underway to ensure resources are shared equitably across the region. New funding over the next three years has been announced to increase capacity within long-term care homes and to continue building community capacity.

The "Dementia Capacity Planning Project" is using methodology to develop local capacity plans. It is a collaborative project between the Ministry, Cancer Care Ontario, Ontario Brain Institute and Institute for Clinical Evaluative Studies. The dementia capacity planning framework will be sustainable and replicable and will inform the broader provincial Health System Capacity Planning Framework. A draft dementia capacity planning tool is in development.

Continuous Quality Improvement: The NE LHIN will continue its work to ensure quality health care services are available for Northerners when they need them. We will continue to implement the regional quality improvement plan (QIP) of our Regional Quality Table. In collaboration with Health Quality Ontario, we will continue to increase capacity for quality improvement and support our health service providers through the development and implementation of quality standards. A key focus of our work within quality will be to improve transitions from hospital through improved discharge follow-up.

Consistency with Government Priorities

- Patients First
- LHIN Renewal Transformation Projects
- 2018-19 Mandate Letter
- Provincial Assess and Restore Guidelines
- Behavioural Services Ontario
- Health System Capacity Framework
- Dementia Capacity Planning Project
- Choose Wisely Canada
- Aging with Confidence: Ontario's Action Plan for Seniors

Goal: Support Development of Sub-Region / Care Communities Strategy

Actions to meet the goal:	Target Status March 2019	Target Completion
Support further development of local Collaborative Tables.	Complete	Mar 2019
Refine sub-region and community data to inform quality improvement.	Complete	Jun 2018
Develop outcome focused plans aligned with Patients First and Minister's Mandate Letter.	Complete	Mar 2019

Measures of Success

- # of Collaborative Tables leveraged/ formed that support Sub-Region development.
- Evidence that the databases contain information at the Sub-Region and Health Link/ local level.
- Action plans launched by Collaborative Tables to guide change management and quality improvement.

Risks / Barriers and Mitigation Plans

Risk: Time commitment by health and social system partners.
Mitigation: Leverage existing tables to the extent possible.

Goal: Improve Patient Flow Between Care Settings (ALC Avoidance / Reduction)

Actions to meet the goal:	Target Status March 2019	Target Completion
Implement ALC Avoidance Framework to identify improvement priorities.	In progress	Ongoing
Support local ALC tables in communities to identify local improvement opportunities.	In progress	Ongoing
Implement and monitor patient repatriation process and agreement.	Completed	Jun 2018
Enhance hospital and community capacity to facilitate patient flow.	In progress	Ongoing

Measures of Success

- Reduction in the overall LHIN ALC rate and four large (HUB) hospital ALC rates.
- Timely and seamless 48-hour repatriation of patients measured by CritiCall's repatriation module.
- High utilization of surge and transitional capacity where implemented in the region.

Risks / Barriers and Mitigation Plans

Risk: ALC avoidance framework requires ongoing change management.
Mitigation: The LHIN has created a regional patient flow lead position to support hospitals.

Goal: Support Adoption of Best Practices Related to Integration

Actions to meet the goal:	Target Status March 2019	Target Completion
Support health service providers expressing interest in integration.	Completed	Jun 2018
Update the NE LHIN Integration Strategy.	Completed	Jan 2018
Update Community Voluntary Integration Toolkit.	Completed	Sept 2018
Provide education to stakeholders on the updated Strategy.	Completed	Mar 2019
Implement strategy with providers showing interest in voluntary integration.	In progress	Ongoing

Measures of Success

- Number of providers completing voluntary integration following a submission of a Business Case.
- Revised strategy and tool kit is approved by the NE LHIN.
- Number of Education sessions completed by March 31, 2019.
- Number of community voluntary integrations initiatives that use the revised strategy by March 31, 2019.

Risks / Barriers and Mitigation Plans

- No known risks

Goal: Enhance Transportation Services So People Can Get To and From The Care They Need		
Actions to meet the goal:	**Target Status March 2019**	**Target Completion**
Phase 1 of non-urgent patient transportation (NUPT) program operational.	Completed	May 2018
NUPT Phase 1 partner reporting system implemented.	Completed	Jun 2018
Phase 2 service, resource requirements, funding plan complete.	Completed	Mar 2019

Measurements of Success

- Delivery of more than 12,000 hours of dedicated NUPT services across the region (Phase 1).
- Non-urgent waiting areas at Health Sciences North and Timmins and District Hospital.
- Phase 2 plan developed and supported by pertinent hospital and District Social Services Administration Board (DSSAB) partners.

Risks / Barriers and Mitigation Plans

Risk: Sustainability of services by transportation service providers.
Mitigation: Project management, reporting and governance structures.

Risk: Sufficient service volumes and utilization.
Mitigation: Orientation for participating hospitals, close monitoring and remediation.

Risk: Phase 2 will only proceed through a cost-sharing model similar to Phase 1.
Mitigation: Partner engagement and Phase 1 results will demonstrate the value of the model.

Goal: Support Redevelopment of, and Access to Long-Term Care Homes (LTCH)		
Actions to meet the goal:	**Target Status March 2019**	**Target Completion**
Participate in redevelopment discussions with operators and Ministry.	In progress	2025
Identify LTCH operators/ partners to incorporate short stay services.	In progress	2025
Enhance opportunities for short stay convalescent care and respite beds.	In progress	Mar 2019

Measures of Success

- Implementation of work arising from joint Ministry / LHIN / Operator meetings.
- Increase in number of applications submitted to Ministry for acceptance into program.
- Increase in number of operators accepted into program.
- Increase in number of operators with an accepted development agreement.
- Number of LTCH operators planning to add a short stay program into redevelopment plans.
- Occupancy of respite beds greater than 55%.

Risks / Barriers and Mitigation Plans

Risk: Capacity and alignment of available licenses with identified local future bed requirements.
Mitigation: Collaborative efforts and open dialogue with Ministry and operators on key policy components.

Risk: Level of LTCH participation in redevelopment efforts.
Mitigation: Early and ongoing engagement with stakeholders to understand viability requirements, particularly for supporting basic accommodation and redevelopment of small homes.

Risk: Identification of the optimum balance of long and short stay beds.
Mitigation: LTCHs will be engaged through network and committee participation to ensure positive experience.

Goal: Identify Priority Population Health Strategies and Integrate Across the Continuum of Care Through Formal Partnerships with Public Health Units, NOSM and Other Key Partners

Actions to meet the goal:	Target Status March 2019	Target Completion
Formalize collaboration between the NE LHIN and the five public health units by identifying common population level priorities and opportunities to work.	In progress	Ongoing
Reorient health care services to move beyond clinical and curative services to primary and secondary prevention models.	In progress	Ongoing
Consolidate population health data and analysis between Public Health Units and the LHIN.	In progress	Ongoing
Implement regional fall prevention best practice: Stay on Your Feet (SOYF) through a renewed agreement with the five public health units.	In progress	Ongoing
Improve health equity across the region by building on the Northern Ontario Equity Strategy and the collective work of the five public health units, the LHIN and Health Quality Ontario.	In progress	Ongoing

Measures of Success

- Written agreement between the LHIN and the five public health units outlining the commitment.
- Number of primary and secondary prevention interventions integrated into the workflow of health care providers.
- Number of collaborative data summaries created through the public health and LHIN partnership.
- Written agreement established with the five public health units to advance the SOYF strategy past March 2018.
- Number of health equity priorities and work plans established between five public health units and the LHIN.
- A collaborative system approach to improvement mental health and addiction outcomes established between public health, the LHIN and all relevant parts of the system.

Risks / Barriers and Mitigation Plans

Risk: Thorough understanding between partners of the unique and common mandates and approaches.
Mitigation: Host discussions to learn from and celebrate partnerships – build on what is working.

Risk: Level of participation of health service providers in identification and implementation of strategies to improve population health.
Mitigation: Identify ways to integrate prevention into the current workflow of health care services.

Risk: Level of participation of health service providers in identification and implementation of strategies to improve health equity across the region.
Mitigation: Facilitate the agreement of the top priorities, alignment on collaborative action plans.

Goal: Increase Timely Access to Standardized Rehab Care and Support

Actions to meet the goal:	Target Status March 2019	Target Completion
Implement recommendations from Rehab Care Capacity Planning Report.	In progress	Mar 2020
Align inpatient and community rehabilitative care with standardized definitions framework for bedded levels of rehabilitative care.	In progress	Mar 2020

Measures of Success

- Implementation of Rehabilitative Care Capacity Action Plan and Development of relevant performance scorecards.
- Full adoption of the Rehabilitative Care Standardized Definitions of Care across all rehabilitative care settings.
- Percentage of admissions to rehabilitative care beds that were directly admitted from community/emergency departments.
- Percentage of patients directly admitted to a rehabilitative care bed from the community who were discharged home.

Risks / Barriers and Mitigation Plans
Risk: Level of health service provider participation in implementation of the standardized definitions.
Mitigation: Appropriate governance structure developed to oversee the action plan.

Goal: Enhance Dementia / Behavioural Supports Ontario (BSO) Services for Seniors and their Caregivers

Actions to meet the goal:	Target Status March 2019	Target Completion
Re-design existing BSO services and investments to maximize access.	Completed	Mar 2019
Implementation of the Provincial and NE LHIN Dementia Strategy.	In progress	Mar 2020

Measurements of Success

- Equitable distribution of current BSO Investments.
- Increase in number of appropriate BSO referrals through the BSO centralized intake.
- Implementation of initiatives related to the Provincial three Year Dementia Strategy.

Risks / Barriers and Mitigation Plans
Risk: Health service provider participation in re-design of BSO current investments.
Mitigation: Leverage lessons learned from other LHINs and input from health service providers on re-design plans

Goal: Ensure Availability Of Quality Health Care Services When People Need Them.

Actions to meet the goal:	Target Status March 2019	Target Completion
Implement NE Regional Quality Table's Integrated Regional Quality Plan (QIP).	In progress	Mar 2020
Collaborate with Health Quality Ontario to increase capacity for quality improvement.	In progress	Mar 2021
Support health service providers to develop and implement Quality Standards.	Completed	Mar 2019
Improve patient transitions from hospital through improved discharge follow up.	In progress	Mar 2020

Measures of Success

- Based on the measures identified in the Integrated Regional Quality Plan (currently in development).
- 50% of staff in health service providers trained in basic quality improvement techniques (minimum of 120 by March 31st 2019).
- Minimum of one representative from the North East on every Quality Standard Committee.
- 100% uptake of a priority from the effective domain across all sectors requiring QIPs.
- Participation by LHIN-funded agencies in town hall meetings for the Quality Standard for Transitions from Hospital.

Risks / Barriers and Mitigation Plans
Risk: Fulsome support across the region's health care system to implement actions in the plan.
Mitigation: Fully engage with health service providers through education efforts.

Risk: Level of participation in Quality Improvement training.
Mitigation: Ensure sessions are scheduled in geographic areas of need, at minimal cost and flexible times.

Risk: Interest of health service providers to participate in the quality standard committees.
Mitigation: Promote value of participation, roster interest in advance of open calls to ensure success.

Risk: Health service providers focus on QIP priorities.
Mitigation: Engage health service providers early. Communicate the potential return.

Priority #2: Mental Health and Addictions

Priority Description

The NE LHIN is committed to Mental Health and Addictions (MH&A) system transformation through six domains including: core services, access and transition, data, funding, quality, and governance.

Goal

Enhance a coordinated and client-centered approach to MH&A.

Current Status

MH&A issues have a significant impact on the delivery of health care and quality of life. The NE LHIN is streamlining the delivery of services so that people can get the help they need in a timely manner and as close to where they live as possible. Every year, the NE LHIN invests about $75 million in 48 organizations delivering a wide range of MH&A services.

Compared to the province, Northeastern Ontario has a higher rate of:

- Suicides and self-inflicted injuries (19% vs 11%).
- Mood Disorders (8% vs 7%).
- People with multiple chronic diseases.
- People aged 15 and older hospitalized for mental health issues.
- Self-injury hospitalizations (In 2010/11 the NE was the second highest in the province)

A comprehensive **NE Addictions Services Review** was conducted to outline service strengths, gaps, and challenges faced by Northerners in accessing services. Access, coordination, and system sustainability were the three themes identified in keeping with the NE LHIN's current priorities for enhanced patient care across the region. In addition, a **Regional Mental Health and Addictions Advisory Council** established a two-year work plan featuring priorities aligned with the recommendations outlined in the NE Addictions Services Review:

- Bring providers together to improve the continuum of services, achieving better health outcomes.
- Transform the system to one that improves access to care and services for the NE LHIN region.
- Support a culture of recovery-oriented practice (ROP) at a policy, program, and practice level.
- Improve health outcomes of Indigenous Populations.
- Recognize that people with MH&A lived experience require safe, affordable, and appropriate housing with additional support if needed.
- Develop strategies to engage, reduce, and prevent the number of people experiencing chronic homelessness.
- Improve outcomes for people accessing mental health and addictions support through increased care connections between primary care providers and the emergency department, hospital, front-line community and culturally appropriate services.
- Ensure people who experience MH&A conditions can access a Primary Care Provider.

Consistency with Government Priorities

- Patients First
- LHIN Renewal Transformation Projects
- 2018-19 Mandate Letter
- Provincial Mental and Addictions Strategy
- Ontario Opioid Strategy

Goal: Enhance a Coordinated and Client-Centred Approach to MH&A Services		
Actions to meet the goal:	**Target Status March 2019**	**Target Completion**
Implement Regional MH&A Advisory Council work plan including Regional Addictions Services Review recommendations.	Completed	Aug 2018
Align with Provincial leadership tables.	Completed	Mar 2019
Certify service providers to use standardized addictions assessment tools.	In progress	Mar 2020
Adjust multi-sector service accountability agreements to mandate use of tools.	In progress	Mar 2020
Implement related strategies of NE LHIN Aboriginal Health Care Reconciliation Action Plan.	In progress	Mar 2020
Implement Opioid Strategy across the NE LHIN.	Completed	Dec 2017
Increase housing opportunities and supports for people living with MH&A.	In progress	Mar 2020

Measures of Success

- Linkages established between sub-region MH&A planning tables and regional MH&A Advisory Council.
- Number of health service providers involved in planning and implementation allowing for regional alignment of priorities.
- Number of provincial recommendations translated to the sub-region level.
- Number of health service providers fully implementing standardized addictions screening tools.
- Stakeholder engagements to measure outcomes of the programs.
- Decrease in opioid-related emergency room visits, hospital admissions, and accidental overdoses.
- Decrease in repeat unscheduled emergency room visits within 30 days for MH&A conditions.

Risks / Barriers and Mitigation Plans

Risk: Embrace of change in approach to service delivery.
Mitigation: Apply change management approach to redefine how MH&A services are delivered in the NE LHIN.

Risk: Fullsome participation and engagement of health service providers.
Mitigation: Ongoing collaboration with health service providers, Regional MH&A Advisory Council and Local Aboriginal Health Committee.

Risk: Level of participation in from programs that might need assistance to provide culturally safe practices.
Mitigation: Work with the NE LHIN Indigenous Lead to assist with engaging agencies that require assistance.

Priority #3: LHIN-Delivered Home and Community Care

Priority Description

With input from patients, caregivers, and partners we are creating a unified and strengthened home and community care sector. This includes overarching efforts to reduce wait times, and improve coordination and consistency of home and community care (HCC) so that clients and caregivers know what to expect. The NE LHIN will continue to implement the initiatives of Patients First: A Roadmap to Strengthen Home and Community Care.

Goals

- Implement "One Client – One Plan"
- Implement collaborative service delivery models for Home and Community Care
- Coordinate End of Life / Palliative Care
- Link Home and Community Care Coordinators to Primary Care settings
- Implement Levels of Care Framework
- Implement Family Managed/Self Directed Care
- Guide the implementation of Wound Care Quality Standards

Current Status

Wait Times: The NE LHIN continues to work to improve wait times for home and community care. Through a focused approach on improving access to therapy services, there has been an overall 58% reduction in wait times in the past 22 months, from 76 to 32 days. The percentage of home care patients with complex needs who received their first personal support visit within five days of service authorization improved from 80.8% to 88.7%. The percentage of home care patients who received their first nursing visit within five days of service authorization increased slightly from 93.7% to 94.7%.

Home and community care has been strengthened as a result of the **Priority Assistance to Transition Home (PATH) Program** which has provided the services and supports needed to help over 6000 northern seniors get home safely from hospital. Regulatory changes made to **Personal Support Services** has enabled the NE LHIN to seamlessly transition more than 400 low acuity patients to community support providers. The NE LHIN supports a website that provides up-to-date online information about health services available to Northerners. Northeasthealthline.ca helps people connect with services they need to stay healthy and independent at home – services like meal delivery, transportation, adult day programs, assistive devices, palliative care, and caregiver respite.

Palliative Care: The Ministry has set a capacity planning formula for palliative services. In any Ontario community, it can be anticipated that 1% of the population will die an expected death over the next twelve months. Capacity needs to be developed to support these individuals in various care settings:

- 63% in home and community care and long-term care (personal residence, retirement home, assisted living)
- 25% in hospital (acute, emergency department and complex continuing care)
- 12% in hospice

Medical Assistance in Dying (MAiD): In September 2017, the NE LHIN was the first to provide provincially funded MAID training to interested physicians and nurse practitioners.

Consistency with Government Priorities

- Patients First
- LHIN Renewal Transformation Projects
- 2018-19 Mandate Letter
- Bringing Care Home: Report of the Expert Group on Home and Community Care
- Personal Support Services Regulatory Amendment
- Ontario Palliative Care Network
- Medical Assistance in Dying – Ontario
- Aging with Confidence: Ontario's Action Plan for Seniors

Goal: Implement "One Client One Plan" (OCOP)		
Actions to meet goal:	**Target Status March 2019**	**Target Completion**
Establish centralized intake to improve integration of home and community care services.	In Progress	Aug 2020
Establish standard process for identifying available services.	In Progress	Dec 2019
Establish standard home and community care assessments.	In Progress	Aug 2019
Establish standardized approach to coordination of all home and community care services.	In Progress	Mar 2020

Measures of Success

- 95% of home care patients with complex needs receiving their first personal support visit within 5 days.
- 95% of home care patients who receive their first nursing visit within 5 days.
- Decrease in wait times from community for in-home services to 21 day provincial target.
- Existing IT assets leveraged / enhanced.
- Implementation of provincial dashboards.
- Client/Caregiver Experience Evaluation Survey results.

Risks / Barriers and Mitigation Plans

Risk: Demand for services given aging population.
Mitigation: Alignment with Patients First vision, transparency of accountability, and leveraging of partnerships.

Risk: Availability of health human resources.
Mitigation: Share health human resource best practices and planning across sub-regions.

Risk: Level of participation of stakeholders.
Mitigation: Process improvement cycle to demonstrate that all stakeholders are critical to service delivery

Risk: Providers without appropriate technology and related infrastructure to meet "One Client One Plan" needs.
Mitigation: Promote adoption of technology solutions including Health Partner Gateway.

Goal: Implement Collaborative Service Delivery Models		
Actions to meet the goal:	**Target Status March 2019**	**Target Completion**
Support ongoing implementation of Rural Health Hubs.	Completed	Mar 2019
Increase housing opportunities and supports for vulnerable populations.	In Progress	Ongoing
Support ongoing implementation of Bundled Care.	In Progress	Ongoing
Enhance access to Personal Support Services in alignment with Ministry strategy.	In Progress	Ongoing

Measures of Success

- Leverage technology for electronic sharing of coordinated care plans across providers.
- Full implementation of PSS regulatory amendments.
- Full implementation of Rural Health Hubs.
- "Innovative Housing with Health Supports in NE Strategic Plan: 2016-2019" implemented.
- Identification of immediate Personal Support Worker (PSW) supply challenges.
- Strategies identified to increase net new Personal Support Worker supply to indicate current PSW challenges
- Strategies identified to maximize existing capacity within the region.

Risks / Barriers and Mitigation Plans

Risk: Limited availability of Health Human Resources, especially in rural areas.
Mitigation: Share health human resource best practices and planning across sub-regions including use of technology.

Goal: Implement Levels of Care Framework		
Actions to meet the goal:	**Target Status March 2019**	**Target Completion**
Compare Levels of Care Framework to current state to determine impact on current volumes.	Completed	Oct 2017
Develop plan to transition patient allocations using the current assessment tool, RAI-HC to Levels of Care Framework.	In Progress	Mar 2020
Participate in provincial working group to develop and inform the *Provincial Core Competencies Care Coordination Framework* for home and community care	In progress	May 2018
Support Provincial pilot of the Levels of Care Framework.	In progress	Sept 2018
Socialize Levels of Care Framework with Care Coordinators.	Planned	Oct 2018
Revise current allocation guidelines and related personal support policies and procedures based on finalized Levels of Care Framework.	Planned	Post-Pilot
Measures of Success • Updated budget that reflects changes in personal support allocation related to Levels of Care Framework. • Provincial pilot completed and changes to Level of Care endorsed by NE LHIN. • Development of provincial Core Competencies Care Coordination Framework for HCC support that reflects NE LHIN values.		
Risks / Barriers and Mitigation Plans: None currently identified		

Goal: Implement Family-Managed / Self-Directed Care (SDC)		
Actions to meet the goal:	**Target Status March 2019**	**Target Completion**
Develop process for prioritization and wait listing.	Completed	Mar 2019
Develop eligibility criteria and process.	Completed	Mar 2019
Develop SDC Agreement and related processes using Ministry template.	Completed	Mar 2019
Develop processes and formalize enrollment/onboarding activities.	Completed	Mar 2019
Develop processes for reassessment / program continuation.	Completed	Mar 2019
Develop process to validate patient/substitute decision maker compliance with program.	Completed	Mar 2019
Develop processes for reporting, off-boarding and transitioning to adult care.	Completed	Mar 2019
Develop coding and tracking practices in electronic record.	Completed	Mar 2019
Measurements of Success • Maintain cost per unit of service for SDC patients compared to usual care. • Continuity of care for each service. • Decreased complaints by patient/SDM and increased patient/SDM satisfaction and time spent on issues management. • Reduce time from authorization of services to reassessment and revision of the care plan. • Evaluation tools and processes of the program.		
Risks / Barriers and Mitigation Plans **Risk:** Availability of resources to implement pilot. **Mitigation:** Leverage opportunities to connect patients / substitute decision makers with personnel.		

Goal: Guide Implementation of Wound Care Quality Standards		
Actions to meet the goal:	**Target Status March 2019**	**Target Completion**
Expand secure virtual care for image uploads and eConsultation.	Completed	Mar 2019
Build Enterostomal Therapist (ET) capacity.	Completed	Mar 2019
Adjust process for pediatric wounds – Identification for ET consultation.	Completed	Mar 2019
Plan diabetic foot ulcer offloading device allocation.	Completed	Mar 2019
Offer Wound Care pop-up clinics in rural communities.	Completed	Mar 2019
Support implementation of standards into practice or monitor compliance.	Completed	Mar 2019

Measures of Success

- 20 image uploads per month tracked through the patient's electronic record.
- Mentor in-training nurse for succession planning into ET role.
- Percentage of pediatric patients with wounds appropriately referred for ET consultation.
- Funding for off-load devices equitably allocated to 50 patients in phase 1, then increase to minimum of 100.
- Wound care pop-up clinics offered in two rural communities, collaborate with patients and Primary Care Providers.
- Improved clinical outcomes while maintaining budget.

Risks / Barriers and Mitigation Plans

Risk: Cost to service provider for data usage.
Mitigation: Leverage economies of scale.

Risk: ET services not authorized for patients who could benefit from this service.
Mitigation: Employee education and training related to role of ET and recognizing when ET service should be authorized.

Risk: Level of Ongoing communication with providers and primary care practitioners.
Mitigation: Leverage NE LHIN Primary Care lead and Clinical Leads.

Risk: Ensure that electronic record can demonstrate standards have been met.
Mitigation: Engage business intelligence.

Priority #4: Primary Care

Priority Description

Primary care providers are the front line of the local health system – caring for patients and their families close to home and supporting their journey through the health services they receive. Improving access to primary care for our residents and developing stronger linkages between primary care providers and other parts of the health system is a key quality priority of the NE LHIN. In particular, the NE LHIN is enhancing 'care communities' defined by geography to ensure Northerners have access to a full complement of primary care services and related supports closer to home. Care communities are a local network of health and social service providers working together to integrate care for each person. The NE LHIN is identifying care communities around patients to improve access to health and social services as close to where Northerners live as possible.

Effective primary care is essential to a high performing health system. Lack of timely primary care access can create gaps in care that result in increased use of hospital emergency departments for conditions that could be better managed in the community. Comprehensive primary care focused on chronic disease prevention and management is linked to reduced avoidable emergency department visits and hospitalizations. Given primary care's central role, engagement and collaboration with primary care providers is necessary to improve system integration and achieve efficiencies.

Goals

- Access to inter-professional care teams
- Spread and scale of Health Links
- Embed home and community care coordinators in primary care.

Current Status

In the NE LHIN there are:

- 538 primary care physicians
- 1 Group Health Centre in Sault Ste. Marie (34 family physicians)
- 27 Family Health Teams
- 6 Community Health Centres
- 6 Nurse Practitioner-Led Clinics
- 16 nursing stations
- 3 Aboriginal Health Access Centres

Health Care Connect: Over the past year, the NE LHIN has improved access to primary care, including the active promotion of an improved Health Care Connect program to both patients and primary care providers. Each month the NE LHIN supports over 1000 people in finding a primary care provider using the program.

Telemedicine: The NE LHIN is a pioneer in the use of telemedicine and continues to expand its use, helping patients access care while avoiding unnecessary travel. Year over year, the NE LHIN is Ontario's highest use of telemedicine. In fact 20% of residents in the region have used telemedicine at least once to receive care.

Health Links: The NE LHIN has 14 Health Links at various stages of maturity. Over the past year, a funding allocation methodology was established using the new formula recognizing the unique geography of the NE LHIN and the work to date in implementing the Health Links approach to care.

Inter-Professional Primary Care: An inter-professional approach to primary care has been shown to improve patient experience, population-based care, timely access and chronic disease management. The NE LHIN is applying a community development approach to create business plans to strategically expand access to inter-professional primary care teams.

Consistency with Government Priorities

- Patients First
- LHIN Renewal Transformation Projects
- 2018-19 Mandate Letter
- Primary Care Reform
- Health Care Connect
- Aging with Confidence: Ontario's Action Plan for Seniors

Goal: Access to Interprofessional Care Teams

Actions to meet the goal:	Target Status March 2019	Target Completion
Support implementation of expansion plans to new communities.	In progress	Mar 2019
Identify innovative models (i.e. co-location) to focus on patient need.	In progress	Mar 2019
Develop relationships with non-health providers.	In progress	Mar 2019
Target provincial funding opportunities as they arise.	In progress	Mar 2019
Promote and support the implementation of IDEAS.	In progress	Mar 2019

Measures of Success

- Improved access to primary care and inter-professional providers.
- Number of communities to provide primary care as a system.
- Number of integrations between primary care providers.
- Number of relationships developed.
- Number of Community Mobilization Tables with active primary care participation.
- Rate of emergency visits for conditions best managed elsewhere (per 1,000 population).
- Hospitalization rate for ambulatory care sensitive conditions (per 100,000 population).
- Percent of Acute Care Patients who have had a follow-up with a physician within 7 days of discharge.
- Number of primary care providers registered and attending IDEAS programs.

Risks / Barriers and Mitigation Plans

Risk: Level of physician involvement.
Mitigation: Modify opportunities for involvement in planning to be inclusive.

Risk: Data and performance is not available at the local community level.
Mitigation: Use sub-region planning and qualitative data to reflect 'boots on the ground' information.

Goal: Spread and Scale of Health Links Approach to Care

Actions to meet the goal:	Target Status March 2019	Target Completion
Improve maturity of identification of complex patients.	Completed	Mar 2019
Improve maturity of coordination of care.	Completed	Mar 2019
Improve maturity in patient-centered care.	Completed	Mar 2019
Improve maturity in measurement and performance.	Completed	Mar 2019
Implement CHRIS/HPG as eHealth solution for all Coordinated Care Plans.	Completed	Mar 2019
Expand Health Link approach to care accountability to all sectors.	Completed	Mar 2019
Improve knowledge transfer and best practices among providers and frontline staff.	Completed	Mar 2019

Measures of Success

- Using the Pan-LHIN Maturity Journey Domains, 13/14 NE Health Links at Level 3 - "Functional Excellence."
- 100% of Coordinated Care Plans in CHRIS/HPG solution and all participating agencies have access to CHRIS/HPG.
- LHINs to explore opportunities for common approaches to accountability mechanisms provincially, and implement.
- Expanded Community of Practice offering core education offerings.

Risks / Barriers and Mitigation Plans

Risk: Delays in database upgrades (CHRIS/HPG) upgrades for coordinated care plans.
Mitigation: Continue to improve pilot project outcomes while provincial standards are in development.

Risk: CHRIS/HPG integration with Primary Care electronic medical records (EMRs) incomplete.
Mitigation: Different approach to coordinated care plan development within CHRIS/HPG, and/or delayed implementation with primary care providers.

Risk: Delays with common approaches to accountability mechanisms.
Mitigation: Alignment with provincial direction to ensure alignment in 2019-20.

Goal: Link Care Coordinators and System Navigation to Primary Care		
Actions to meet the goal:	**Target Status March 2019**	**Target Completion**
Develop strategy for phase two expansion including reporting standards.	Completed	Apr 2018
Create a standardized agreement template for linking activities.	Completed	Apr 2018
Update operational toolkit outlining responsibilities of stakeholders.	Completed	Apr 2018
Leverage technology and improve communication with primary care providers.	Completed	Dec 2018
Data-cleanse health records to identify primary care provider and Primary Care group.	Completed	Feb 2018
Evaluation framework that includes patient outcomes, patient and provider satisfaction.	Completed	Mar 2019

Measures of Success

- Standardized agreement template.
- Toolkit completed and available.
- 100% of Primary Care Providers engaged in embedding model discussions.
- 75% of Primary Care Providers connected with HPG view.
- <25% of Primary Care Providers refusing to connect.
- Patient, provider and care coordinator satisfaction surveys with >75% satisfied/very satisfied rating.
- MLAA outcomes for patients improved quarter over quarter.
- Percentage of shared patients seen quarterly in joint meetings.

Risks / Barriers and Mitigation Plans

Risk: Level of participation of primary care providers.
Mitigation: Clinical Lead involvement for promotion; evaluation activities to outline value; build trusting relationships between home and community care and primary care providers; communications tools to raise awareness.

Risk: Level of Care Coordinator participation.
Mitigation: Internal awareness and sharing of information to develop shared understanding of roles.

Priority #5: Digital Health

Priority Description

Champion digital health technologies to support system transformation.

Goal

Support Implementation of 10 Point Digital Health Action Plan.

Current Status

As a result of the expansive geography and distributed population, the NE LHIN has established itself as a pioneer in the adoption of digital health solutions. Telemedicine has become an essential tool in clinical service provision with 20% of our population experiencing a telemedicine visit during the course of a year. The NE LHIN is consistently the most active user of clinical telemedicine in Ontario.

Health Information System (HIS) Renewal in the NE LHIN has three components**:**

1. Installation of Meditech 6.1x that will serve as the regional electronic medical record (EMR) for all 24 acute hospitals.
2. Create a new business entity to deliver best model information technology (IT) services in the LHIN drawing on expertise across the region.
3. Establish regional governance that includes hospitals and other system partners to set digital priorities for the region.

All 24 acute-care hospital Boards have committed to work together to achieve this goal. Part of this project aims to have our Northeastern clinicians work together to determine best practices for looking after patients through clinical processes and documentation which will be standardized for use across our LHIN region where and when it makes sense.

Consistency with Government Priorities

- 2018-19 Mandate Letter
- Provincial 10-Point Digital Health Action Plan

Actions to meet the goal:	**Target Status March 2019**	**Target Completion**
Point 2 of 10: Expand virtual technologies into home, community and primary care.	In progress	Ongoing
Point 7 of 10: Expansion of eReferral, eConsult, eNotification and transition of physician office integration (POI) to Hospital Report Manager (HRM).	In progress	Ongoing
Point 9 of 10: Maximize value of HIS investments aligned with panel recommendations.	In progress	Ongoing

Measures of Success

- Installation of online support for mental health.
- Installation of eReferral for the orthopaedic care pathway by 2018/19.
- Increase enrollment to eNotification by 10% by 2018/19.
- Installation of three hospitals within the provincial Meditech Collaborative HIS Hub.

Risks / Barriers and Mitigation Plans

Risk: Number of licenses for the mental health and addictions on-line support.
Mitigation: Work with OTN to increase the number of licenses given the remoteness and availability of services.

Risk: Timely integration of eReferral within existing systems.
Mitigation: Current state analysis to understand gaps, opportunities to integrate all systems.

Priority #6: French Language Health Services

Priority Description

Language and culture play an essential role in the provision of health care services. One quarter of people living in Northeastern Ontario are identified as French-speaking. The NE LHIN is committed to an integrated approach to French language services.

Goal

Increase access to services in French and ensure designated agencies continue to meet criteria.

Current Status

The NE LHIN is a culturally and linguistically vibrant and distinct region. According to the 2011 census, there are 125,085 Francophone in the NE LHIN region (22% of the population) - the largest number of Francophones, by region, in the province. As per the 2011 census, the following table identifies the total Francophone population per sub-region.

NE LHIN Planning Area	Total population	Total Francophone Population	% of Francophone Population
Algoma	115,870	7,410	6.40%
Cochrane	77,831	36,395	46.76%
James and Hudson Bay	5,407	30	0.55%
Nipissing and Temiskaming	125,954	27,915	22.16%
Sudbury, Manitoulin, Parry Sound	226,082	48,335	21.38%

The NE LHIN, in collaboration with the French Language Health Service Planning Entity (FLHPE), plans for French Language Services (FLS) implementation at the sub-region level. Monitoring of FLS progress through annual FLS reports will help identify potential candidates for FLS designation. Support for designation plan development and compliance with FLS criteria is provided in collaboration with the FLHPE. The NE LHIN will continue to lead the evaluation process to ensure continued FLS Act compliance by designated health service providers. Currently, forty-two NE LHIN agencies are designated for the provision of French Language Services; and 56 are identified.

Active Offer principles and links to resources are included in the on-line NE LHIN FLS toolkit for health service providers. The NE LHIN, in collaboration with the FLHPE, continues to identify opportunities to present to providers on the principles of active offer. Support is provided to health service providers in developing active offer guidelines and monitoring will be possible through the annual FLS report. The FLHPE is developing a training module for health service providers on active offer.

The NE Healthline (www.northeasthealthline.ca) identifies service providers that offer services in French. The list of health service providers that are identified and designated for FLS are included on the NE LHIN's website. The NE LHIN will continue to use communication strategies, such as communiqués, annual reports and NE LHIN bulletins.

Consistency with Government Priorities

- French Language Services Act, 1986
- Patients First
- 2018-19 Mandate Letter

Actions to meet the goal:	Target Status March 2019	Target Completion
Identify patient journey gaps for Francophone Northerners.	In progress	Ongoing
Increase active offer strategies with identified and designated health service providers.	Completed	Mar 31, 2019
Support three health service providers to submit a designation plan.	Completed	Mar 31, 2019
Evaluate 13 designated health service providers to ensure continued compliance with the FLS Act.	Completed	Mar 31, 2019

Measures of Success

- Number of documented Francophone patient experiences.
- Number of health service providers that adopt an Active Offer approach.
- Number of activities by NE LHIN and/or the FLHPE to promote active offer.
- Number of health service providers that submit a designation plan to the NE LHIN.
- Number of evaluations completed.

Risks / Barriers and Mitigation Plans

Risk: Lack of bilingual human resources.
Mitigation: Adopt best practices for recruitment together with FLHPE.

Risk: Level of health service provider compliance with French language services reporting and obligations.
Mitigation: Educate health service providers on designation process and provide support with the assistance of the FLHPE.

Risk: Inconsistent data collection methodologies and information systems inability to capture language data.
Related Mitigation Plan: Monitor and report French language services data and promote importance of standardized data collection.

Priority #7: Indigenous Peoples

Priority Description

The NE LHIN is committed to advancing Indigenous health initiatives that help to increase access and improve coordination of health programs and services for Indigenous Northerners.

Goal

Implement 24 calls for action of ***NE LHIN Aboriginal Health Care Reconciliation Action Plan***.

Current Status

The Indigenous diversity within the NE LHIN includes Cree, Ojibwa, Odawa, Algonquin and Métis peoples and represents about 11% of the total population. In general, Aboriginal people experience a lower health status than other Northerners, including:

- Higher rates of chronic health conditions such as diabetes, hypertension and mental health disorders.
- Physical aging at a younger age due to multiple chronic conditions.
- Higher cases amongst Aboriginal youth of mental health issues, chronic illnesses and poor oral health.
- High rates of suicide and suicide ideation.
- First Nations people are over-represented as clients in addiction services.

Consistency with Government Priorities

- Patients First and 2018-19 Mandate Letter
- The Journey Together: Ontario's Commitment to Reconciliation with Indigenous Peoples
- North East LHIN Aboriginal Health Care Reconciliation Action Plan

Actions to meet the goal:	**Target Status March 2019**	**Target Completion**
Identify patient journey gaps and improve transitions of care for Indigenous Northerners.	In progress	Ongoing
Develop plans and create opportunities in a culturally sensitive manner.	In progress	Ongoing
Collaborate with federal and provincial partners to improve coordination with First Nations.	In progress	Ongoing
Promote quality data collection for Indigenous population groups.	In progress	Ongoing
Provide guidance to the NE LHIN's Local Aboriginal Health Committee (LAHC) in implementing the NE LHIN Reconciliation Plan.	In progress	Ongoing

Measures of Success

- Distribution and completion of the 'Aboriginal Health Practices across Northeastern Ontario' survey. The results of the survey will serve as baseline data for initiatives outlined in the NE LHIN Reconciliation Plan.
- Number of health care professionals successfully completed online Indigenous Cultural Safety training.
- Expansion of local cultural competency training to front-line health service providers including the region's 4 large (HUB) hospitals and 20 small hospitals across the Northeast for 2017/18 and 2018/19.
- Linkages and engagement with Indigenous communities aligned with the five sub-region planning tables.
- Number of health service provider work plans that are culturally-based and responsive.
- Number of responses to 'calls for applications' for Indigenous Inter-professional Primary (IPC) Teams.
- Number of responses to 'calls for applications' for Indigenous mental health and wellness programs and services.
- Number of Indigenous-led and Indigenous-informed mental health programming and services using traditional and cultural healing as treatment.
- Active participation and engagement with Federal, Provincial and Regional partners to align efforts.
- Ongoing support to providers to include Indigenous health in data collection reporting guidelines.
- Bi-annual Local Aboriginal Health Committee (LAHC) engagement meetings to measure and review annual progress

of the NE LHIN Reconciliation work plan and discuss new strategies.
Risks / Barriers and Mitigation Plans **Risk:** Level of Indigenous representation on sub-region planning tables. **Mitigation:** Creation of Indigenous-led table in the five sub-regions
Risk: Level of involvement and participation in Indigenous cultural safety training. **Mitigation:** Use a traditional cultural teacher to spread cultural mindfulness training to health care providers and professionals within the Northeast region as a commitment to the journey of reconciliation.
Risk: Gaps and/or deficits in baseline data collection to accommodate the holistic quadrants of Indigenous ways of health and healing. **Mitigation:** Work in partnership with Indigenous organizations with a focus on health equity to examine the health needs of Indigenous people on a consistent basis. Concept mapping/health survey/storytelling of the community needs will help to generate respondent driven profiles in order to create regional data base on the collection of stories from the Indigenous population.

Table A: LHIN Spending Plan

	2017/18 Estimated Actuals	2018-2019 Allocation	2019-2020 Planned Expenses	2020-2021 Planned Expenses
Allocation: HomeCare/ LHIN Delivered Services				
Salaries (Worked hours + Benefit hours cost)	$ 39,194,004	$ 41,738,231	$ 41,738,231	$ 41,738,231
Benefit Contributions	$ 9,999,719	$ 10,612,640	$ 10,612,640	$ 10,612,640
Med/Surgical Supplies & Drugs	$ 6,186,683	$ 5,938,463	$ 5,938,463	$ 5,938,463
Supplies & Sundry Expenses	$ 3,139,864	$ 2,286,495	$ 2,286,495	$ 2,286,495
Equipment Expenses	$ 2,578,731	$ 2,731,330	$ 2,731,330	$ 2,731,330
Amortization on Major Equip, Software Licence & Fees	$ -	$ -	$ -	$ -
Contracted Out Expense	$ 77,682,179	$ 74,906,734	$ 74,906,734	$ 74,906,734
Buildings & Grounds Expenses	$ -	$ -	$ -	$ -
Building Amortization	$ -	$ -	$ -	$ -
TOTAL: Home Care/LHIN Delivered Services	**$ 138,781,180**	**$ 138,213,893**	**$ 138,213,893**	**$ 138,213,893**
Allocation: Aggregated Operation of the LHIN	**2018-2019**	**2018-2019**	**2019-2020**	**2020-2021**
Salaries (Worked hours + Benefit hours cost)	$ 3,384,889	$ 3,618,415	$ 3,618,415	$ 3,618,415
Benefit Contributions	$ 679,388	$ 641,879	$ 641,879	$ 641,879
Med/Surgical Supplies & Drugs	$ -	$ -	$ -	$ -
Supplies & Sundry Expenses	$ 1,436,479	$ 359,362	$ 359,362	$ 359,362
Equipment Expenses	$ -	$ -	$ -	$ -
Amortization on Major Equip, Software Licence & Fees	$ -	$ -	$ -	$ -
Contracted Out Expense	$ 716,161	$ -	$ -	$ -
Buildings & Grounds Expenses	$ -	$ -	$ -	$ -
Building Amortization	$ -	$ -	$ -	$ -
Sub-total: LHIN Operations	$ 2,751,697	$ 2,751,697	$ 2,751,697	$ 2,751,697
Sub-total: LHIN Operations Initiatives	$ 2,955,220	$ 1,867,959	$ 1,867,959	$ 1,867,959
Sub-total: LHIN Operations Digital Health	$ 510,000	TBD	TBD	TBD
TOTAL: Aggregated Operation of the LHIN	**$ 6,216,917**	**$ 4,619,656**	**$ 4,619,656**	**$ 4,619,656**
Allocation: Integrated LHIN Administration/Governance	**2018-2019**	**2018-2019**	**2019-2020**	**2020-2021**
Salaries (Worked hours + Benefit hours cost)	$ 7,354,176	$ 7,759,016	$ 7,759,016	$ 7,759,016
Benefit Contributions	$ 1,758,710	$ 1,831,770	$ 1,831,770	$ 1,831,770
Med/Surgical Supplies & Drugs	$ -	$ -	$ -	$ -
Supplies & Sundry Expenses	$ 2,503,934	$ 1,830,200	$ 1,830,200	$ 1,830,200
Equipment Expenses	$ 788,750	$ 1,015,339	$ 1,015,339	$ 1,015,339
Amortization on Major Equip, Software Licence & Fees	$ -	$ -	$ -	$ -
Contracted Out Expense	$ -	$ -	$ -	$ -
Buildings & Grounds Expenses	$ 2,254,207	$ 2,037,354	$ 2,037,354	$ 2,037,354
Building Amortization	$ -	$ -	$ -	$ -
TOTAL: Integrated LHIN Administration/Governance	**$ 14,659,777**	**$ 14,473,678**	**$ 14,473,678**	**$ 14,473,678**
TOTAL: LHIN SPENDING PLAN	**$ 159,657,874**	**$ 157,307,228**	**$ 157,307,228**	**$ 157,307,228**

Notes:

1. Home Care/LHIN Delivered Services envelope includes direct services as defined in Schedule 7, Table 1 of the 2015-2018 Ministry LHIN Accountability Agreement.
2. Aggregated Operations of the LHIN includes:
   i. LHIN Operations: LHIN's mandated system operations/activities related to planning, funding and integrating.
   ii. iLHIN Operations Initiatives: Activities that are one-time and/or require separate reporting as per ministry funding letters. (E.g. French Language Services and Aboriginal Engagement).
   iii. LHIN Operations Digital Health: The coordinated and integrated use of electronic systems, information and communication technologies to facilitate the collection, exchange and management of personal health information in order to improve the quality, access, productivity and sustainability of the healthcare system.
3. Integrated LHIN Administration/Governance envelope includes indirect costs such as administration and overhead expenses of the combined organization.

Table B: LHIN Staffing Plan (FTE)

	2017/18 Actuals as of February 2017/18	2018-2019 Forecast	2019-2020 Forecast	2020-2021 Forecast
HomeCare/ LHIN Delivered Services[2]				
Management and Operational Support (MOS) FTE	172.69	178.79	178.79	178.79
Unit Producing Personnel (UPP) FTE	354.47	361.03	361.03	361.03
Nurse Practitioner (NP) FTE	9.99	10.92	10.92	10.92
Physician FTE	0.00	0.00	0.00	0.00
TOTAL: Home Care/LHIN Delivered Services FTE	**537.15**	**550.74**	**550.74**	**550.74**
LHIN Operations[3]				
Management and Operational Support (MOS) FTE	23.43	25.66	25.66	25.66
Unit Producing Personnel (UPP) FTE	0.00	0.00	0.00	0.00
Nurse Practitioner (NP) FTE	0.00	0.00	0.00	0.00
Physician FTE	0.00	0.00	0.00	0.00
TOTAL: LHIN Operations FTE	**23.43**	**25.66**	**25.66**	**25.66**
LHIN Operations Initiatives[4]				
Management and Operational Support (MOS) FTE	4.30	6.38	6.38	6.38
Unit Producing Personnel (UPP) FTE	0.00	0.00	0.00	0.00
Nurse Practitioner (NP) FTE	0.00	0.00	0.00	0.00
Physician FTE	0.00	0.00	0.00	0.00
TOTAL: LHIN Operations Initiatives FTE	**4.30**	**6.38**	**6.38**	**6.38**
LHIN Operations Digital Health[5]				
Management and Operational Support (MOS) FTE	3.65	0.00	0.00	0.00
Unit Producing Personnel (UPP) FTE	0.00	0.00	0.00	0.00
Nurse Practitioner (NP) FTE	0.00	0.00	0.00	0.00
Physician FTE	0.00	0.00	0.00	0.00
TOTAL: LHIN Operations Digital Health FTE	**3.65**	**0.00**	**0.00**	**0.00**
Integrated LHIN Administration/Governance[6]				
Management and Operational Support (MOS) FTE	48.15	48.54	48.54	48.54
Unit Producing Personnel (UPP) FTE	38.27	36.87	36.87	36.87
Nurse Practitioner (NP) FTE	0.00	0.00	0.00	0.00
Physician FTE	0.00	0.00	0.00	0.00
TOTAL: Integrated LHIN Administration/Governance FTE	**86.42**	**85.41**	**85.41**	**85.41**
TOTAL FTE SUMMARY	**654.95**	**672.51**	**672.51**	**672.51**

Integrated Communications Strategy

Business Objectives

The NE LHIN's 2018/19 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), including: improve access to and wait times for services, increase the coordination of care Northerners need, and strengthen system sustainability so Northerners can rely on a strong health care system today and tomorrow.

As well, it takes into account our renewed *Strategic Directions* (fall 2017) to *"improve the health of our population by building capacity to increase access to quality integrated care for Northerners, including Francophone and Indigenous people"*. While we are working to strengthen the full continuum of care, our three areas of focus to build capacity are: primary care, home and community care, and mental health and addictions care. We will leverage five levers to make progress: championing; digital health technologies; including patients in our decision making; holding ourselves and our health service providers accountable; focusing on population health and equity; and working in partnership with patients, providers, and community residents

Listening to the voices of Northerners continues to be a core value of the NE LHIN and we continue to focus on integrating the voices of patients and families into our initiatives through community engagements and the involvement of our Patient and Family Advisory Committee.

We will continue to work with partners to drive system quality and value, and to improve 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 voices 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 to and coordination of health care services.
    - The system is sustainable, being effectively managed, and providing value for tax dollars.
    - Progress is being made to improve the patient experience.
    - The system is transparent and accountable.
- 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, and help people to navigate the system through an increased awareness of the health care options that are available to them.
- Leverage governance and operational engagements to help build strong relationships based on trust with our health service providers and fellow Northerners that will improve patient experience, system performance and health outcomes.

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. Guided by that objective, it sets out clear goals for Ontario's health care system: 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. As part of the Action Plan, LHINs continue to have a critical role 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.

LHINs are further guided by the mandate letters from the Minister of Health and Long-Term Care (MOHLTC) that reinforce 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, our renewed 2018 Strategic Direction, and the initiatives laid out in this Annual Business Plan are strategically aligned with government directions and recognize the joint accountability of the MOHLTC and LHINs to serve the public interest and effectively oversee the use of public funds.

As this year is the final year of our current IHSP, we will be engaging with Northerners to develop our fifth IHSP in partnership with fellow Northerners, health service providers, our Patient and Family Advisory Committee, the Réseau du mieux-être francophone du Nord de l'Ontario and our Local Aboriginal Health Committee.

Target Audience

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, Services de santé en français, Secretariat for Aboriginal Affairs, Seniors' Secretariat, MPPs, Municipal Government Officials, Councils, Mayors, Reeves, First Nations Chiefs and Councils, and CEOs.
- Academic Institutions
- Partner Organizations
- Réseau du mieux-être francophone du Nord de l'Ontario (French Language Health Service Planning Entity – FLHSP); 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

Key Messages

NE LHIN

- 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.
- The NE LHIN is committed to comprehensive community engagement that helps to inform and guide its work to improve the patient experience, outcomes and performance of the Northeastern Ontario health system.
- Northerners are important partners in the NE LHIN's health system transformation efforts.
- People Matter – the NE LHIN asks, listens, and responds.
- 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.

- The 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 authorities, primary care providers, community leaders and the public.
- Engaging with Northerners at a local level – within sub-regions – is vital when determining the health care priorities of each community.

Provincial

- Ontario is increasing access to care, reducing wait times and improving the patient experience through its Patients First: Action Plan for Health Care - protecting health care today and into the future.
- The Patients First: Action Plan for Health Care sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre by improving the health care experience: increasing access, connecting services, informing patients and protecting our health care system.
- 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.
- Changes underway supported by the *Patients First Act* have expanded the LHIN mandate and will give LHINs the tools, oversight and accountability they need to better integrate local health care services and coordinate care across the care continuum in a way that better serves patients.
    - In May and June 2017, home care services and staff transferred from CCACs to LHINs. This was a structural system change that will help patients and their families get better access to a more local and integrated health care system. The process happened in carefully planned stages and was seamless for patients and home care clients. There was no disruption to care and providers remained the same.
- Once fully implemented, these changes 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.
- Administration of the health care system will be streamlined and reduced, with savings put back into improving patient care.
- With Patient and Family Advisory Councils (PFAC) in every LHIN, 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.

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 work whenever possible – using their stories and experiences to inspire action and keep the 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 health system manager for Northeastern Ontario.
- 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 sub-regions.
- Provide information on performance and progress on the implementation – document successes and share it.

Tactics – high level

- Patient/Family/Caregiver information is widely available: www.nelhin.on.ca; www.northeasthealthline.ca; 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
- Community Engagements
- Participation in information-sharing events – workshops, conferences, community tables
- NE LHIN Annual Report
- Board Meetings

Evaluation

Identifying/tracking communication success factors to identify whether communication activities have been successful, including:

- 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.
- 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.
- Health service providers 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?
- Evaluate feedback received from patients, caregivers, and the public through correspondence, complaints, and compliments.
- 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.

***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*:** Support 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 (LAHC) on key issues and challenges faced by Indigenous people in the region. The NE LHIN also works to ensure there is Indigenous people representation on its other committees and advisory groups. Our LAHC is consulted on key engagement efforts such as our 2019-2022 IHSP.

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. In addition, the Réseau has a community consultation structure – health hubs – to engage Francophones across the North East in a continuous manner. Information from the LHIN and the Réseau community engagement processes helps to inform the FLS priorities in the North East, based on the needs and concerns of the Francophone community. The NE LHIN, NW LHIN and Réseau have a joint three-year health action plan aimed at enhancing care coordination, improving the patient experience, increasing access to services in French, reducing inequities, and strengthening the sustainability of French Language Services. The joint action plan is aligned with the NE and NW LHIN IHSP priorities and the intent is to continue to ensure alignment of IHSP and JAP.The plan is available online on the NE LHIN website here.

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

Ontario

Local Health Integration Network

Réseau local d'intégration des services de santé