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

NORTH EAST LOCAL HEALTH INTEGRATION NETWORK

Annual Business Plan
2014/15

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

Table of Contents

TRANSMITTAL LETTER FROM THE NORTH EAST LHIN BOARD CHAIR

September 25, 2014

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

Dear Ms. McCulloch,

The North East Local Health Integration Network (NE LHIN) is pleased to provide you with our 2014/2015 Annual Business Plan (ABP) as required by the Local Health System Integration Act, the Ministry/LHIN Memorandum of Understanding, and the Ministry/LHIN Performance Agreement (MLPA).

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

Determined through discussions and extensive engagement with more than 4,000 Northerners, the four priorities of our IHSP are:

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

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

We continue to focus our efforts on shifting the local health care system from a provider-centred system of care to a more patient-centred one. Knowing that our region spans 44% of Ontario's land mass and is home to 4.1% of its population, our efforts to break down silos, encourage system integration and increase access to care closer to where people live will continue in earnest. With 19% of our population age 65 and over (projected to increase to 30% by 2036), higher rates of chronic disease and complex medical issues, the need for more care to be provided at home, in community, and centred on the needs of Northerners continues to guide our LHIN efforts and decisions.

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

Sincerely,

Danielle Bélanger-Corbin
Chair

MANDATE AND STRATEGIC DIRECTIONS

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

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

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

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

The North East LHIN's 2013-2016 Integrated Health Service Plan (IHSP) is aligned with Ontario's action plan and the needs of Northerners as voiced in extensive engagements over the past several years. These engagements with fellow Northerners and health service providers continue on a regular basis and combined have a great impact on the North East LHIN's decision making and areas of focus.

OVERVIEW OF CURRENT AND FORTHCOMING PROGRAMS/ACTIVITIES

The North East LHIN funds about 150 health services providers across six sectors; including:

- Hospitals (25)
- Community Health Centres (6)
- Community Mental Health & Addictions (48)
- Community Support Services (63)
- Long-Term Care Homes (41)
- Community Care Access Centre (1)

Over the coming years, the North East LHIN will continue to work in collaboration with health service providers to move our health system from provider to patient-centred, and to ensure outcomes and evidence drive every aspect of delivering quality care to Northerners. System realignment and enabling technologies will be key to this shift, as will our commitment to maintain and further develop strong relationships with health service providers and community partners.

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

North East LHIN IHSP Summary, 2013 – 2016

Ontario's Action Plan For Health Care

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

LHIN System Imperatives

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

North East LHIN Priorities

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

By 2016, the North East LHIN will:

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

ENVIRONMENTAL SCAN

In 2014, the NE LHIN has about 171 accountability agreements which hold health care service providers accountable to deliver $1.4 billion in front-line health care each year. These agreements include:

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

The North East LHIN has structured its large geographic area into five HUB planning areas which were created based on hospital referral patterns. These HUBS help to support local planning and realignment efforts when working to enhance care of Northerners closer to where they live.

Access to Health Services

In terms of primary care, the North East region has approximately 600 primary care physicians, one Group Health Centre in Sault Ste. Marie, 27 Family Health Teams, six Community Health Centres, six Nurse Practitioner-Led Clinics, 16 Nursing Stations and three Aboriginal Health Access Centres.

The Health Care Connect Program began in February 2009 in Ontario and has helped Northerners connect with primary care providers. Between February 2009 and May 2014, 63,626 NE LHIN residents had registered with the program and nearly 80% had been referred to a family health care provider. The North East is the highest user of Health Care Connect (HCC) in Ontario.

Life Span

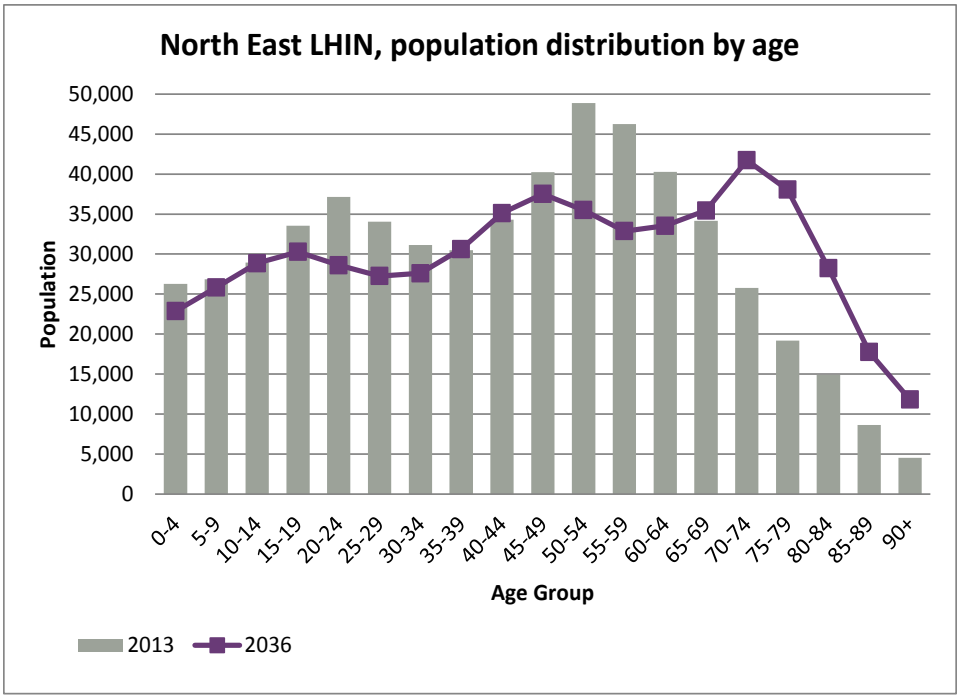
Both male and female NE LHIN residents have a shorter life expectancy than residents of Ontario: 76.5 years for males (79.2 years in Ontario), and 81.4 years for females (83.6 in Ontario).

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

Premature mortality, a measure of death rates (per 100,000 population) prior to age 75, is 35% higher in the NE LHIN compared to the province.

There are approximately 129,000 Francophones (23%) living in Northeastern Ontario, including Marie-Anne Huneault (right), who receives care from Personal Support Worker (PSW) Gaetanne Bigras (left) at the West Nipissing General Hospital in Sturgeon Falls.

New/Emerging/Evolving Drivers of System Change



Population Change

The North East LHIN population is projected to change dramatically over the next two decades. The information to the left is based on Ministry of Finance, Ontario projections. Only 1% overall population growth is expected by 2036 but the proportion of the population age 65 and over is projected to increase from 19% to 30%. This is an increase of 65%. This significant demographic shift has major implications on the delivery of health care and the type and location of services delivered.

Health Practices and Health Status

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

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

(The information above is from Statistics Canada - both the 2011 Census and the Community Health Profile 2013.)
*Ontario percentages also include Northeastern Ontario percentages.

HEALTH SYSTEM PERFORMANCE

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

Report on MLPA Performance Indicators (Status as of Q1, 2014/15)

	Performance Indicator	LHIN 2014/15 Starting Point	LHIN 2014/15 Target	Quarter 1 2014/15	% from Target for Quarter Result
Access to healthcare services (Objective: To enhance person-centred care. Expected outcomes: Persons will experience improved access to healthcare services identified below in alignment with best practices.)					
1	90th percentile ER length of stay for admitted patients (hrs.)	29.57	25	30.65	22%
2	90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients (hrs.)	5.87	6.5	5.63	On target
3	90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients (hrs.)	4.0	4.0	4.0	On target
4	Percent of priority IV cases completed within access target (84 days) for cancer surgery	95%	90%	91%	On target
5	Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	100%	90%	100%	On target
6	Percent of priority IV cases completed within access target (182 days) for cataract surgery	91%	90%	91%	On target
7	Percent of priority IV cases completed within access target (182 days) for hip replacement	71%	85%	70%	18%
8	Percent of priority IV cases completed within access target (182 days) for knee replacement	58%	75%	62%	17%
9	Percent of priority IV cases completed within access target (28 days) for MRI scans	73%	80%	55%	31%
10	Percent of priority IV cases completed within access target (28 days) for CT scans	81%	83%	75%	9%
Integration and coordination of care (Objective: To improve system integration and enhance coordination of care while ensuring better transitions to various care settings. Expected outcomes: Persons will be able to navigate the health care system and receive the care they need, when and where they need it.)					
11	Percentage of Alternate Level of Care (ALC) Days	24%	22%	25%	13%
12	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management) (days)	70	48	95	97%
Quality and improved health outcomes (Objective: To implement evidence-based practice to drive quality and value and improve health outcomes. Expected outcomes: Persons will receive quality inpatient care and coordinate post-discharge care, leading to reduced admission rates that may improve survival, quality of life, and other outcomes without increasing cost.)					
13	Readmission within 30 Days for Selected CMGs	17.6%	15%	18.8	25%
14	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions	17.6%	16.5%	16.5%	On target
15	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions	31.4%	25%	23.8%	On target

REPORT ON MLPA PERFORMANCE INDICATORS

Access to Healthcare Services

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

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

Improving Access to Surgery and Diagnostics

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

- **Cancer Surgery**: For those patients assessed as Priority IV, over 90% completed their surgery within the access target of 84 days, meeting the NE LHIN's target.
- **Cardiac Surgery**: For those patients assessed as Priority IV, 100% completed their surgery within the access target of 90 days, meeting the NE LHIN's target.
- **Cataract Surgery**: For those patients assessed as Priority IV, 91% completed their surgery within the access target of 182 days.
- **Hip Replacement Surgery**: For those patients assessed as Priority IV, 70% completed their surgery within the access target of 182 days. Service demand in the NE LHIN is 2.5 patients requiring surgery for every surgery completed. The NE LHIN is pursuing opportunities to improve surgical throughput including: 1) capacity enhancement strategy to enable additional surgeries in 2014/15; 2) reallocating surgical volumes between hospital, as appropriate and, 3) reviewing opportunities to "repatriate" surgeries completed on NE LHIN residents outside of the NE LHIN. In addition, the NE LHIN's five Joint Assessment Centres (JACs)

provide comprehensive assessments by Advanced Practice Physiotherapists who advise patients on options including the need for a consultation with a surgeon in anticipation of joint replacement and other options such as physiotherapy to manage at home. The JACs are ensuring the right patients are getting to surgery, surgeons are being utilized efficiently to treat people who are candidates for surgery, and people are promptly informed of the opportunity to see the next available surgeon.

- **Knee Replacement Surgery**: For patients assessed as Priority IV, 62% completed their surgery within the access target of 182 days. Service demand in the NE LHIN is 3.5 to 4 patients requiring surgery for every surgery completed. The NE LHIN is pursuing the same opportunities for knee surgery as employed to improve hip surgical through-put.
- **MRI Scans**: For patients assessed as Priority IV, 55% received their MRI scan within the access target of 28 days. Overall, the NE LHIN has the third best wait time for MRI in the province when access is assessed against all patients. High demand across the four hospitals providing MRI is a key factor, especially in Sudbury at the regional hospital.
- **CT Scans**: For patients assessed as Priority IV, 75% received their CT scan within the access target of 28 days. High demand across the four large urban hospitals is contributing to longer waits for Priority IV patients. At the regional teaching hospital (Health Sciences North) programs such as neurosurgery, trauma, cardiovascular surgery and advanced cancer diagnostics contribute to high demand for CT scans in Sudbury.

Integration and coordination of care

- **Percentage of Alternate Level of Care (ALC) Days**: Extended hospital stays for patients who require an alternate level of care (ALC) occur as a result of delays in discharge to their next destination, (e.g. long-term care or community-based care). At 25%, the NE LHIN is above target. While fluctuations in ALC are inevitable (typically high in winter months), ALC remains a top priority for the NE LHIN. A wide array of strategies are in place to improve the transition of hospitalized patients to their next destination. As discussed under ER performance above, these strategies range from building community capacity to support seniors in their homes (e.g. assisted living, telehomecare) to supporting those health service providers who ensure that "Home First" is the priority for all patients. Currently one of the region's large urban hospitals, Sault Area Hospital, is experiencing ALC pressures that are inhibiting patient flow. ALC is addressed at local and regional planning tables and the NE LHIN is working with partners to ensure local solutions are in place to assist with strengthening the continuum of care.
- **Wait Time for CCAC In-Home Services**: At 95 days, the amount of time that homecare clients are waiting for their first service is above target (48 days). The NE CCAC is working to reduce wait times by focusing first on people who have been waiting the longest. The NE LHIN's analysis of NE CCAC operations identified clients who are waiting for therapy services, such as occupational therapy, as some of the longest "waiters" on their client lists. The CCAC has focused on offering different approaches to providing services such as group settings in varied locations. The CCAC has emphasized recruitment of its own therapy staff, especially in locations which have historically been under-serviced. These efforts have paid off with 100% employment of existing vacancies. Some parts of the NE LHIN, particularly more remote small communities, remain underserviced with respect to CCAC services. Innovations, such as engaging with the local hospital to provide an "integrated" therapy service, have been deployed (Hornepayne) and are being considered for other communities. In August 2014, the NE CCAC committed to implementing the 16 recommendations arising out of the joint NE LHIN/NE CCAC Collaborative Capacity Analysis. The implementation of the recommendations is expected to result in enhancements to the way people receive CCAC services across the region.

Quality and improved health outcomes

- **Readmission within 30 Days for Selected Case Mix Groups**: Hospital readmission rates for selected chronic conditions remain above target. Initiatives across the NE LHIN will contribute to reducing unnecessary hospitalizations such as: Congestive Heart Failure (CHF) Clinic (Sudbury), ER CHF initiatives (Sault Ste. Marie), Chronic Obstructive Pulmonary Disease (COPD) Clinic (North Bay), Rapid Response Nursing (North Bay, Sault Ste. Marie, Sudbury, Timmins), Telehomecare and others. The development of Health Links is wrapping comprehensive care plans around complex patients who often require hospitalization. Attention to primary care through increasing referral rates of Health Care Connect may initially result in some new hospitalizations and over time will enable patients to stay healthier in their own community. A LHIN-wide Clinical Services Review linked closely to Health System Funding Reform and the roll-out of Quality Based Procedures will ensure more standardized quality care across all hospitals in the region. Many hospital Quality Improvement Plans (QIP) have identified hospital readmissions as a priority focus.

- **Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**: Repeat emergency room visit rates for mental health are at target. Revisit rates mean that each quarter there are approximately 500 repeat visits to NE LHIN ERs related to mental health conditions. NE LHIN investments in crisis support in downtown Sudbury are providing an alternative location for mental health supports for those in crisis. This model is new to the region and in a short period of time is demonstrating a positive impact on those needing assistance as well as early indication of reduction in ER visits and police escorts to the ER. North Bay is implementing a similar model. Across the NE LHIN, a regional “Warm Line” provides after-hours (night) telephone access for individuals seeking assistance. The Ontario Psychiatric Outreach Program, a pilot initiative with Family Health Teams which started in January 2014, is enhancing service access for patients with mental health conditions. Transitional supportive housing (8 units) have been implemented in Sudbury to enable the transition from hospital to community for patients.

- **Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**: Repeat emergency room visit rates are below target. These rates mean that each quarter there are approximately 250 repeat visits to NE LHIN emergency rooms for substance abuse conditions. Data analysis has confirmed that a small number of patients contribute to high revisit rates related to substance abuse and more specifically to alcohol related conditions. NE LHIN investments such as addictions counselling in hospital emergency rooms, addictions subsidized housing and supports to addictions recovery homes have been deployed to support patients and clients with substance abuse conditions. In addition, the NE LHIN is investigating a managed alcohol program with community partners.

Increase Primary Care **Coordination**

More than 4,000 Northerners contributed to the North East Local Health Integration Network's (NE LHIN) 2013-2016 strategic plan.

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

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

PRIORITY DETAILS, PLANS AND METRICS

Increase Primary Care Coordination

Priority Description

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

The NE LHIN acknowledges the need for a comprehensive, system-wide strategy to establish a sustainable primary care delivery system that is able to meet the growing and changing needs of Northeastern Ontario. The NE LHIN requires a clear plan to develop a sustainable model of care. The central role played by primary care providers is valuable in developing new, creative models of care delivery, improve system integration and achieve efficiencies. Physician involvement in priority setting, strategy development and health system planning is critical for a more integrated, patient-centred system of care.

This fiscal, the North East LHIN is continuing to focus on improving access, increasing the integration of primary care within the broader continuum of care, and engaging primary care providers in viable solutions.

Current Status

The following is a summary of intiatives underway to move this priority forward.

North East Primary Care Advisory Council
The NE LHIN's Primary Care Advisory is comprised of nurse practitioners and family physicians who provide leadership and advice on issues related to primary care in NE Ontario. Since its start in April 2013, the Council has met between six to eight times a year.

- Terms of reference and work plan are complete and implementation is underway.
- A sub-committee is working on improving communications between primary care providers and the North East Community Care Access Centre.

Health Care Connect
Administered by the NE CCAC, Health Care Connect (HCC) links patients with primary care providers. Data from February 12, 2009 to May 31, 2014 shows that Northeastern Ontario has the largest HCC program in Ontario with most total and complex vulnerable patients registered and referred to a primary care provicer. Effort has been made to improve the percentage of patients connected with a primary care provider, improving from 66.2% in December 31, 2012 to 79.2% as of June 30, 2014.

Scope of Practice
The NE LHIN is part of the Northern Ontario School of Medicine's Health Human Resources committee which is looking at issues related to health human resources in NE Ontario, including the shortage of health care professionals and professionals working to full scope of practice.

Advanced Access and After Hours Care
Primary Care Advisory Council and the Primary Care Physician LHIN Lead are working with other primary care practitioners to promote the advanced access concept, where sick patients are able to see their provider the same or next day.

Expanding Telemedicine within Primary Care Settings
The NE LHIN has embraced the use of the Ontario Telemedicine Network (OTN) as a way to increase access to care,

overcoming vast geographic challenges in retaining/recruiting health human resources and becoming the highest user of telemedicine among the 14 LHINs, with 300 sites, including 26/27 Family Health Teams, 6/6 Community Health Centres, 3/3 Aboriginal Health Access Centres, 6/6 Nurse-Led Practitioner Clinics, and 16/16 Nursing Stations.

The NE LHIN is one of three early adopter LHINs in Ontario to offer the Telehomecare program to people with heart failure or COPD in their own homes. Telehomecare nurses teach, coach and enable patients to actively manage their condition, keeping the primary care provider informed. The NE LHIN now has more than 900 Northerners enrolled in the program.

Interdisciplinary Collaboration
During 2013/14, Diabetes Education Programs (DEPs) provided clinical best practice updates to the Primary Care Providers in their catchment areas. These sessions were also an opportunity to promote the role and function of DEPs to prevent service duplication through interdisciplinary collaboration.

Funding for pilot projects is underway and interdisciplinary collaboration includes: Inter-Professional Health Provider Funding; and Medically Complex Patients Demonstration Project.

The role of the North East Specialized Geriatric Services (NESGS) is promoted to primary care organizations.

The NE LHIN's Health Professional Advisory Committee serves as a collective voice of health professionals and provides the NE LHIN with advice related to the implementation of the Integrated Health Service Plan, the Annual Business Plan and other strategic initiatives as requested by the LHIN. Members represent different health professions, health sectors and geographic areas of the NE LHIN.

Primary Care in Chronic Disease Prevention and Management (particularly for diabetes care)
A Primary Care Diabetes Nurse Practitioner Lead and Diabetes Specialist (endocrinologist) continue to support the NE LHIN with dedicated time to promote Chronic Disease Prevention and Management.

Work is underway to facilitate collaboration agreements between Diabetes Education Programs (DEP) and local primary care providers. Self-referrals are accepted at DEPs to facilitate care for unattached patients. Diabetes Education Programs are encouraged to provide outreach to FHTs and other primary care organizations.

Linking Primary Care to the Rest of the Health Care System
Currently more than 350 physicians and nurse practitioners in the NE LHIN are using Physician Office Integration (POI) with more in the queue to join. Using POI, NE LHIN hospitals have sent more than 800,000 patient discharge summaries, diagnostic imaging and lab reports to a primary care provider's electronic medical record.

The Complex Centre for Diabetes Care is developing a computerized charting system for patients with diabetes.
An inpatient diabetes nurse specialist is being piloted in order to provide inpatient diabetes care and seamless transition from hospital to home including communication with primary care providers.

Rapid Response Nurses from NE CCAC are available to meet with patients discharged from hospital.

76% of all family practice physicians use EMR, and this number is growing.

The NE LHIN, as part of the provincial roll-out of Alternate Level of Care Resource Matching Business Transformation Initiative (RM&R BTI), has achieved Provincial Referral Standards which streamline the complex patient referral environment for the following four care pathways: Acute to Community Care Access Centre; acute to long-term care; acute to rehab; and acute to complex continuing care. An initial implementation is underway at the Sault Area Hospital, Health Sciences North, Manitoulin Health Centre, and Espanola Regional Hospital and Health Centre.

There is a continued need to facilitate linkages between primary care and community services (e.g. through the liaison of

CCAC care coordinators and/or system navigators within primary care practices).

NE CCAC efforts continue to provide timely patient information to primary care practitioners including linking primary care providers with CCAC Care Coordinators (i.e. Care Coordinators being located within primary care practices). CCAC is the designated single point of entry for people requiring physiotherapy services one-on-one at home (as part of physiotherapy reform), a dedicated CCAC physician phone line, standardized communication protocols with primary care providers, emergency department notification of patients over 80 years, Home First program support and access for primary care providers to the CCAC electronic client record.

Health Links and Models of Care

Temiskaming and Timmins are early adopters of Health Links. A readiness assessment has been approved for Kapuskasing/Hearst/Smooth Rock Falls area and within this fiscal they will complete and submit their business case. Sault Ste. Marie and North Bay have submitted their readiness assessments to the MOHLTC. Upon approval, they will complete the business case in 2014/15. Parry Sound is exploring the possibility of establishing a Health Link. Conversations for additional Health Links have started in Sudbury. Health Hubs or a unique community model are in discussion in a number of other small rural communities.

Quality Improvement Initiatives (QIPs)

QIPs have been received from CHCs and most FHTs and work is underway to provide feedback from a community perspective.

Consistency with Government Priorities:

Ministry of Health and Long-term Care direction requires LHINs to engage the primary care sector. The legislation relating to Ontario's LHINs specifies three "communities" to be engaged by the LHINs:

- Patients and other individuals in the geographic area of the network;
- Health service providers and any other person or entity that provides services in or for the local health system;
- Employees in the local health system.

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

Other key policy directions and strategic reports also direct our goals, including:

- Enhancing the Continuum of Care, Dr. Ross Baker, November 2011
- Care for our Aging Population and Addressing Alternative Level of Care, Dr. David Walker, June 2011
- Living Longer, Living Well (2012)
- The development of Health Links across the province as a new model of care for high users of the system.

The MOHLTC has identified five strategic directions for primary care in Ontario:

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

Action Plans	2014/15		2015/16		2016/17	
	Status	%	Status	%	Status	%
Goal 1: Improve access to high quality primary care for Northerners						
Promote Health Care Connect and work to increase patient rostering.	In Progress	20%	In Progress	20%	In Progress	20%
Maximize scope of practice opportunities and strategies.	In Progress	10%	In Progress	20%	In Progress	20%
Promote Advanced Access and after-hours care.	In Progress	20%	In Progress	20%	In Progress	20%
Continue to expand telemedicine within primary care settings.	In Progress	30%	In Progress	30%	In Progress	30%
Promote opportunities for interdisciplinary collaboration.	In Progress	20%	In Progress	20%	In Progress	20%
Goal 2: Increase the integration of primary care within the broader continuum of care						
Support and strengthen the role of primary care in chronic disease prevention and management.	In Progress	20%	In Progress	20%	In Progress	20%
Ensure primary care providers receive timely patient information upon discharge.	In Progress	20%	In Progress	40%	In Progress	40%
Facilitate linkages between primary care and community services.	In Progress	20%	In Progress	20%	In Progress	20%
Goal 3: Engage and collaborate with primary care providers to better support the patient journey						
Establish a North East Primary Care Advisory Council.	Complete	100%	Complete		Complete	
Explore the development of Health Links as a model of care, particularly for high users of the health care system.	In Progress	20%	In Progress	60%	In Progress	20%
Focus on Quality Improvement initiatives that will ensure providers are equipped with current best practice guidelines that will improve patient outcomes.	In Progress	20%	In Progress	20%	In Progress	20%

How will we measure success?

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

- Increase usage of Health Care Connect by residents and Primary Care Providers. *Percentage of patients connected with a primary care provider December 31, 2012 = 66.2%; June 30, 2014 = 79.2%.(Health Care Connect Monthly Data Report, MOHLTC, June 30, 2014)*
- Percentage of adults (aged 16 and older) and children who are unattached. *NE Ontario = 11.0%; Sudbury = 12.0%; Sault Ste. Marie = 7.4% (Health Care Experience Survey, April 2013 to March 2014).*
- Percentage of adults who were able to see a primary care provider when they were sick on the same day or next day. *NE Ontario = 31.2%; Sudbury = 37.6%; Sault Ste. Marie = 28.8% (Health Care Experience Survey, April 2013 to March 2014).*
- Number and rate of emergency visits per 1,000 population (age 1 to 74) for conditions that could be treated in primary care settings. *Q1 2011/12 = 12.9%; Q1 2012/13 = 15.6%;Q1 2013/14 = 11.9% (The Quarterly, 2014-04-04).*
- Reduced 30-day hospital readmission rates for select conditions. *MLPA target = 15%. Current MLPA Performance = 18.8%.*

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

- Increase access to the region's integrated diabetes programs and services. (21 adult diabetes programs and 4 pediatric diabetes programs).
- Number and rate of emergency visits per 1,000 population (age 1 to 74) for conditions that could be treated in primary care settings. *Q1 2011/12 = 12.9%; Q1 2012/13 = 15.6%;Q1 2013/14 = 11.9% (The Quarterly, 2014-04-04).*
- Primary care visits within seven days for patients upon discharge from hospital. *Percentage of patients who visited a primary care practitioner within seven days of discharge from hospital in NE Ontario in Q2 2012/13 = 33.4%; Q4 2012/13 = 33.1%.(The Quarterly, 2014-04-04).*

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

- Establishment of Primary Care Advisory Council and implementation of the annual work plan. *PCAC has been established and is active.*
- Number of operational Health Links Networks. *Temiskaming and Timmins Health Links are early adopters in Ontario and are active.*
- Reduction in acute care admissions for chronic conditions. *Reduced 30-day hospital readmission rates for select conditions. MLPA target = 15%. Current MLPA Performance = 18.8%.*

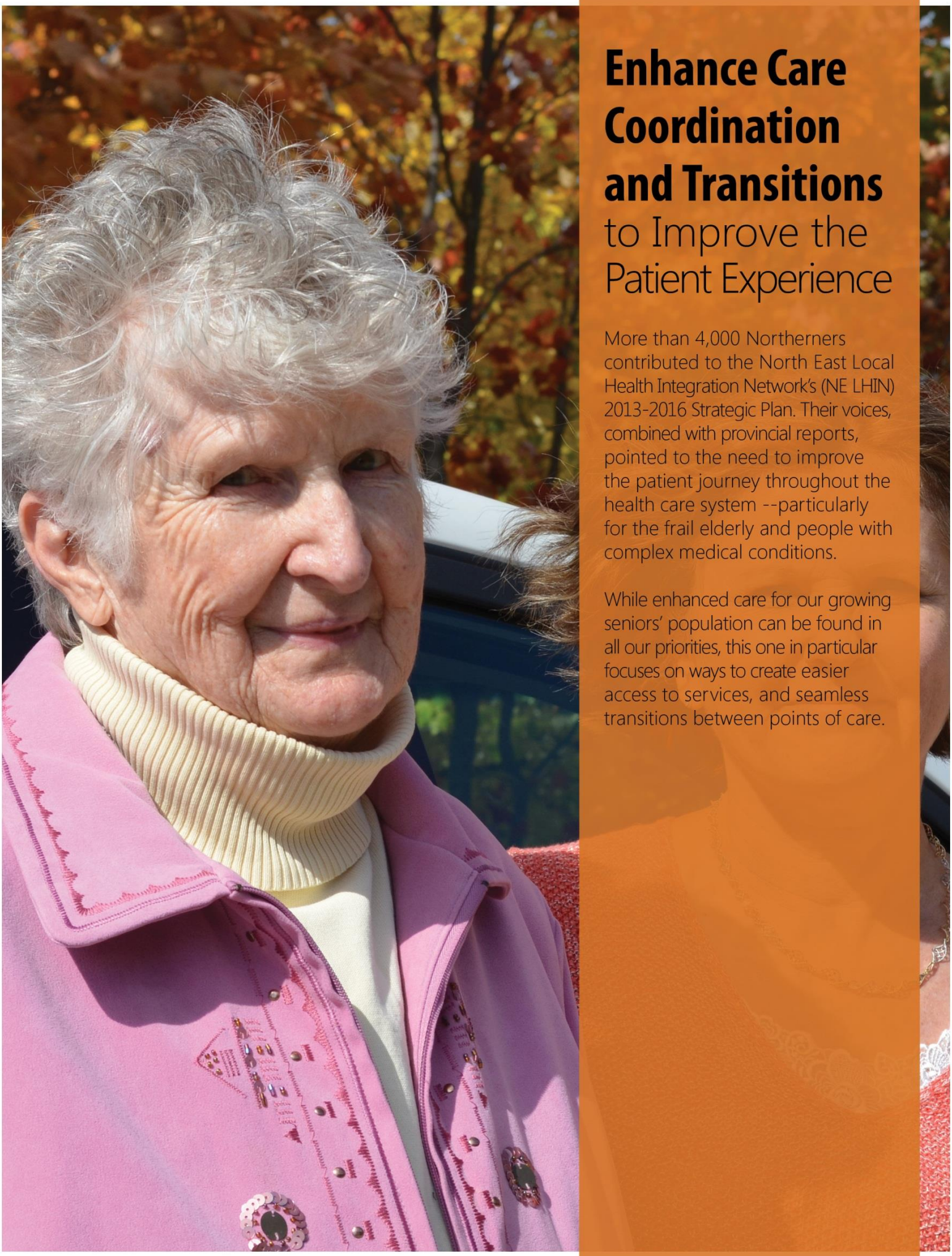
Risks/barriers to successful implementation

- Potential lack of human resources in the Primary Care sector.
- Limited availability of and capacity for primary care practitioners within primary care settings to work on issues of integration.

Key enablers

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

Crystal Noel is one of three new primary care nurse practitioners employed by the North East CCAC in Sudbury, North Bay and Sault Ste. Marie, through North East LHIN funding. These new positions were created to help mainly frail seniors who were discharged home from hospital and did not have a primary care provider.



Enhance Care Coordination and Transitions to Improve the Patient Experience

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

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

Enhance Care Coordination and Transitions to Improve the Patient Experience

Priority Description

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

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

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

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

Current Status

Through the work of the NE LHIN and local partners, health care is evolving from silos of care delivery to patient-centred care. Providing the right care at the right time and in the right place is especially important for seniors and the frail elderly who rely on a strong continuum of care – from hospital to community and home. The population 65+ in the NE LHIN is 19% compared to 14.6% for Ontario as a whole. By 2036, the population 65+ in the North East is projected to grow to 30% of the population or 172,000 persons from the current 100,000 individuals 65+.

The following is a summary of intitatives underway to move this priority forward.

Ontario Senior Friendly Hospital (SFH)
The NE LHIN supports the SFH strategy, including the requirement of hospitals to submit SFH improvement plans during annual HSAA refresh. In addition, three hospitals have been provided with funding to implement the Hospital Elder Life Program which supports the reduction of hospital-acquired delirium and functional decline. In 2014/15, the NE SFH working group will promote more knowledge exchange to move the strategy forward.

Assisted Living
Seniors' assisted living continues to be a priority with close to 1,600 units currently available for seniors and individuals with physical disabilities across the region. In 2013/14 alone, the NE LHIN committed funding to serve over 100 additional clients in assisted living programs. In 2014/15, providers across the region had the opportunity to submit proposals for further expansion of service delivery. The Assisted Living Regional Steering Committee developed a standardized processes to identify the most complex clients and help predict support requirements to divert people from hospital/emergency. By leveraging the InterRAI Community Health Assessment (CHA), organizations upload assessment information to the Integrated Assessment Record to reduce duplicate patient assessments. Two regions of the LHIN piloted the process with further rollout planned this fiscal.

Restorative Care
Through one-time funding, the NE LHIN supported 15 projects to establish a foundation for building capacity for restorative care including identification and intervention. In 2014/15, the restorative care model will continue to evolve based on a Provincial Assess and Restore policy.

Palliative Care
In 2013/14, a hospice palliative care Shared Care Team was approved for Sudbury that brought together interdisciplinary specialists with front-line family physicians and home care nurses to support terminally-ill patients and their family members in the home, hospice or retirement home. This team helps to build capacity in the primary care sector thereby reducing hospital admissions and readmissions for palliative conditions. Several communities are in the process of developing their model for future implementation in 2014/15. In 2013/14, local hospice palliative care community resource teams promoted the services available in their communities and provided public information sessions on advanced care planning. A Health Quality Ontario report shows that advanced care planning improves families' satisfaction with end-of-life care and increases the likelihood of a person spending their last days in the location of their choice. A greater emphasis on public education initiatives is planned for 2014/15.

Physiotherapy Reform
Funding was provided for 29 outpatient Physiotherapy Clinics to increase capacity and improve access across the region. These clinics work with hospitals and other health service providers to strengthen the Rehab System.

Addressing Alternate Level of Care (ALC) Numbers
The NE LHIN has shown significant progress in reducing the ALC rate in acute care over the past few years. From a high of nearly 41% in Q4 10/11, the LHIN dropped to just under 20% in Q1 12/13. This increased to 24% in Q1 13/14 which is close to the NE LHIN target of 22%. Starting in September 2010, the four HUB hospitals and NE CCAC implemented a Home First philosophy, supported by Integrated Discharge Planning (IDP) processes between hospitals and the CCAC. In 2013/14 a new discharge planning program was initiated on Manitoulin Island to assist patients transitioning from home to community in need of support including First Nations clients living on reserve who do not access CCAC services. From April to December 2013, over 900 patients were sent home from the four hub hospitals using enhanced home care services. In the past, many these patients would have been deemed alternate level of care, waiting for long-term care home placement.

North East Joint Assessment Centres
Five NE LHIN supported Joint Assessment Centres work to improve efficiency in managing patient referrals to outpatient physiotherapy services post joint replacement surgery. The goal is a seamless transition from inpatient care to home/community, with minimal wait time and ease of moving along the continuum.

Specialized Geriactric Services
Until 2009, the North East LHIN did not have a geriatrician or specialized geriatric programming. As of 2013, there were two geriatricians, a number of care-of-the-elderly physicians, and a developing North East Specialized Geriatric Services. Given the current and projected seniors' population, the NE LHIN continues to develop specialized geriatric service capacity and linkages both at local and regional levels.

Non Urgent Transportation
In 2013, the NE LHIN began a review of non-urgent inter-facility transportation in the region. The project was completed in the Spring of 2014 and involved a comprehensive current state assessment and development of a future business model and plan. Concurrently, the LHIN funded three six-month pilot projects to test different approaches to non-urgent transportation service delivery. Two of the pilots were extended for an additional six months due to their success.

Consistency with Government Priorities:

This priority and its goals are aligned with key provincial policy directions, including: Enhancing the Continuum of Care, Dr. Ross Baker, November 2011; Caring for Our Aging Population and Addressing Alternative Level of Care, Dr. David Walker, June 2011; Ontario's Action Plan for Health Care, January 2012; Living Longer, Living Well, (2012); Health Links; Physiotherapy Reform; and Assess and Restore programming.

Actions Plans	2014/15		2015/16		2016/17	
	Status	%	Status	%	Status	%
Goal 1 - Improve access and quality through greater service coordination.						
Expand patient navigation in hospital and community.	In Progress	33%	In Progress	33%	Completed	33%
Develop strategies to minimize avoidable (re-) hospitalization for high-risk / high-use patients.	In Progress	20%	In Progress	20%	In Progress	20%
Implement best practices in patient risk assessments and integrated discharge planning.	In Progress	30%	In Progress	30%	Completed	30%
Develop one point of access for community support services per HUB.	In Progress	50%	In Progress	30%	Completed	20%
Goal 2 - Improve client transitions between service providers along the continuum of care.						
Streamline client assessments between providers.	In Progress	40%	In Progress	40%	Completed	20%
Ensure timely sharing of patient information as high-risk clients/patients are discharged from hospital.	Not Yet Started	33%	In Progress	33%	Completed	33%
Partner with primary care providers on continuity of care post-hospital discharge.	In Progress	20%	In Progress	20%	In Progress	20%
Educate patients/clients/caregivers on service availability and options.	In Progress	20%	In Progress	20%	In Progress	20%
Continue to build on Resource Matching and Referral work to use LEAN techniques to efficiently move people throughout the health system.	In Progress	25%	In Progress	25%	In Progress	25%
Continue to implement initiatives to support more senior friendly hospitals.	In Progress	25%	In Progress	25%	In Progress	25%
Goal 3 - Enhance targeted service capacity where required.						
Expand regional North East Specialized Geriatric Services (NE SGS) and support local geriatric service expertise.	In Progress	25%	In Progress	25%	In Progress	25%
Create new service delivery models to better meet the needs of seniors in their own homes.	In Progress	25%	In Progress	25%	In Progress	25%
Expand affordable seniors' assisted living services.	In Progress	20%	In Progress	20%	In Progress	20%
Develop the range and capacity of end of life services (hospice palliative care) across the North East.	In Progress	25%	In Progress	25%	In Progress	25%
Implement a model for non-urgent inter-facility patient transportation across region.	In Progress	50%	In Progress	25%	Completed	25%
Continue to implement BSO Action Plan.	In Progress	80%	In Progress	10%	Completed	10%
Expand community physiotherapy clinics.	Complete	100%				

How will we measure success?

Goal 1: Improve access and quality through greater service coordination.

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

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

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

Goal 3: Enhance targeted service capacity where required.

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

Risks/barriers to successful implementation

- Critical services in the community often do not have the capacity to make the necessary impact. As outlined in the *NE LHIN Seniors' Residential Housing Options – Capacity Assessment and Projections,* March 16, 2009, in order for the supply of seniors' housing to keep pace with projected growth in seniors' population, an increase of 8,409 beds or units over the next 25 years, or an average of 336 per year, is required across the region.
- Health Human Resource recruitment and retention issues to address additional needs especially for Personal Support Workers.
- The change management and time required for process improvement initiatives.
- Factors that are outside the control of the health system that impact on the level and intensity of health services required by seniors (i.e. rate of growth of seniors' population in the NE, social determinants of health).
- At the community level, many of the interventions rely on partnerships with primary care providers who are, for the most part, outside of the current LHIN mandate. As noted in *Enhancing the Continuum of Care: Report of the Avoidable Hospitalization Advisory Panel,* November 2011, these partnerships, as well as increased accountability between partners, are critical to keep medically complex patients out of the ED and hospital.

Key enablers

- Continued e-health solutions to support clinical information sharing between providers
- Expanded LHIN role and responsibility for primary care
- Finalization of province-wide non-urgent patient transportation standards

Make Mental Health and Substance Abuse Treatment Services **More Accessible**

More than 4,000 Northerners have contributed to the North East Local Health Integration Network's (NE LHIN) 2013-2016 strategic plan. One of the four health care priorities identified by fellow Northerners is **Making Mental Health and Substance Abuse Treatment Services More Accessible.**

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

*From *Mental Health and Addictions in Ontario LHINs,* 2008

The North East LHIN is working to help streamline the delivery of mental health and substance abuse services so that people can get the help they need in a more timely manner and as close to where they live as possible.

Make Mental Health & Substance Abuse Services More Accessible

Priority Description

Mental health and substance abuse issues have a significant impact on the delivery of health care and an individual's quality of life. Frequent readmissions and presentations to emergency departments often lead to longer wait times, increased stigma and increased demands on community and hospital services. Through the implementation of innovative initiatives, realignments, integrations and decentralization of some services, as well as improved use of new technologies, the NE LHIN anticipates a significant impact in improving access to service for consumers.

Improved system navigation, increased community treatment capacity and enhanced supports for individuals with complex treatment issues will continue to improve service access and treatment outcomes.

Current Status

The NE LHIN is responsible for a full continuum of community and hospital sponsored mental health and substance abuse services with a total of 48 funded organizations of which 26 provide substance abuse services and 34 provide mental health services. This represents *30,159 individuals (*not unique individuals) engaged in approximately 624,000 interactions with professional treatment staff. To reduce demand and improve access, the NE LHIN has implemented a number of initiatives throughout the region aimed at diverting referrals, decreasing readmissions, and improving access to/and capacity of community services.

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

A number of diversion initiatives to decrease re-visits to emergency departments across the region are showing success, including: placing substance abuse professionals and peer workers in emergency departments, expanding opiate programs for pregnant and parenting moms, increasing addictions housing and case management options, mcentralized access programs, and centralized crisis pilots. The overall number of individuals involved in the high number of revisits remains relatively few; however, the frequency of their visits remains high.

The NE LHIN continues to work with the Ontario Telemedicine Network (OTN), Centre for Addiction and Mental Health (CAMH) and others to increase access to psychiatric resources to family health team patients. The NE LHIN continues pilots that utilize technology to improve access to remote communities to expert mental health/substance abuse professionals.

Consistency with Government Priorities:

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

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

The priorities are also aligned with *The Report of the Select Committee on Mental Health and Addiction 2010*, and the *Ontario Action Plan for Health Care.*

Action Plans	2014/15		2015/16		2016/17	
	Status	%	Status	%	Status	%
Goal 1: Expand system realignment initiatives by HUB to improve access and system navigation for consumers and their families.						
Leverage the use of new technologies and improved communication processes.	Ongoing	75%	Ongoing	10%	Ongoing	10%
Use a "tiered" approach to service provision that	In	50%	In	50%	Complete	100%

places consumer needs at the centre as per the provincial ten year strategy.	progress		progress			
Explore and implement models that streamline processes for access to services.	Ongoing	50%	Ongoing	10%	Ongoing	10%
Implement Mental Health CritiCall in hospitals.	In progress	50%	In progress	10%	In progress	15%
Hold mental health forums to inform the priority.	Forum 1 Complete	100%	Forum 2 in progress		Forum 3 in progress	
Decentralize 12 children's mental health specialized tertiary beds/program.	In Progress	90%	Complete	100%	Complete	100%
Goal 2: Increase community treatment capacity to provide more care options for consumers and their families while decreasing pressures on the acute sector.						
Work with our mental health partners to develop programs that incorporate the use of peer support workers, where possible.	Ongoing	25%	Ongoing	25%	Ongoing	25%
Realign resources to enhance community mental health capacity.	Ongoing	35%	Ongoing	35%	Ongoing	30%
Implement the use of new quality of service indicators to monitor client/consumer treatment experience.	Pending release new tool	10%	In progress	50%	Complete	100%
Engage with primary care physicians to find effective ways to integrate mental health and substance abuse treatment services into their practice.	In progress	50%	In progress	10%	In progress	15%
Implement the opiate treatment strategy.	Complete	100%	Complete	100%	Complete	100%
Goal 3: Enhance care supports for individuals with complex issues by working closely with health community sectors, ministries and governments.						
Work collaboratively with partners - including Education, Ministry of Children and Youth Services, and children's mental health services - to implement best approaches to helping transitional aged youth.	In progress	20%	In progress	80%	Complete	100%
Work with partners to implement BSO plan.	In progress	75%	Ongoing	15%	On going	10%
Work with the Regional Human Service Justice Coordinating Committee and implement initiatives to assist individuals with mental health and substance abuse issues at risk of coming into conflict with the criminal justice system.	In progress	30%	Ongoing	35%	Ongoing	35%
Implement initiative placing nurses with mental health expertise with school boards across the region.	Complete	100%	Complete	100%	Complete	100%

How will we measure success?

Goal 1: Expand system realignment initiatives by HUB to improve access and system navigation for consumers and their families:

- 90% implementation of IAR across NE LHIN mental health and addiction sector.
- 100% OTN sites established in all WMS programs and Opiate case management programs.
- Tiered model implemented in 60% newly integrated substance abuse/mental health services in NE LHIN.

- Implementation of offsite crisis centres in four hub hospital communities and establishment of centralized access in one community.
- 100% implementation of stage one of bed registry across the region.
- Mental Health forum (2014/15 & 2015/16).
- Two Tertiary beds operational Sault Ste. Marie and Timmins and 4 beds operational in Sudbury and North Bay (complete) and four meetings annually of the regional network.
- Establishment of centralized access initiative in Algoma.
- Establishment of mobile crisis in Nipissing.

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

- Continue to work with Consumer Survivor Initiative (CSI) programs and providers to ensure that there are a minimum of four initiatives across the region that incorporate the use of paid peer support workers.
- Implementation of realignments across the region.
- Implementation of new CAMH clients experience of treatment survey tool in all substance abuse/mental health providers in NE LHIN.
- Implementation of Store Forward pilot in Sault Ste. Marie and evaluation report completed.
- Six opiate case managers placed in agencies across the region and programs now operating.
- Completed Ontario Psychiatric Outreach Program (OPOP) pilot with CAMH that sees specific psychiatrists coupled with 4 family health teams.
- Implementation of mental health mobile home care.
- Full implementation of Addiction Treatment Services Needs Assessment in Nipissing.
- Work with community partners on a possible Managed Alcohol Program harm reduction program in Sudbury.

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

- Once available the LHIN will work with health service providers to implement the Dual Diagnosis guidelines.
- The LHIN will participate on Ministry of Child & Youth Services, Ministry of Community & Social Services committees looking at transitional youth issues.
- Decentralize and monitor the 12 children's mental health tertiary beds completed.
- BSO initiatives ongoing and active throughout the region.
- Implementation of "Rebound" program in Sault Ste. Marie and Sudbury.

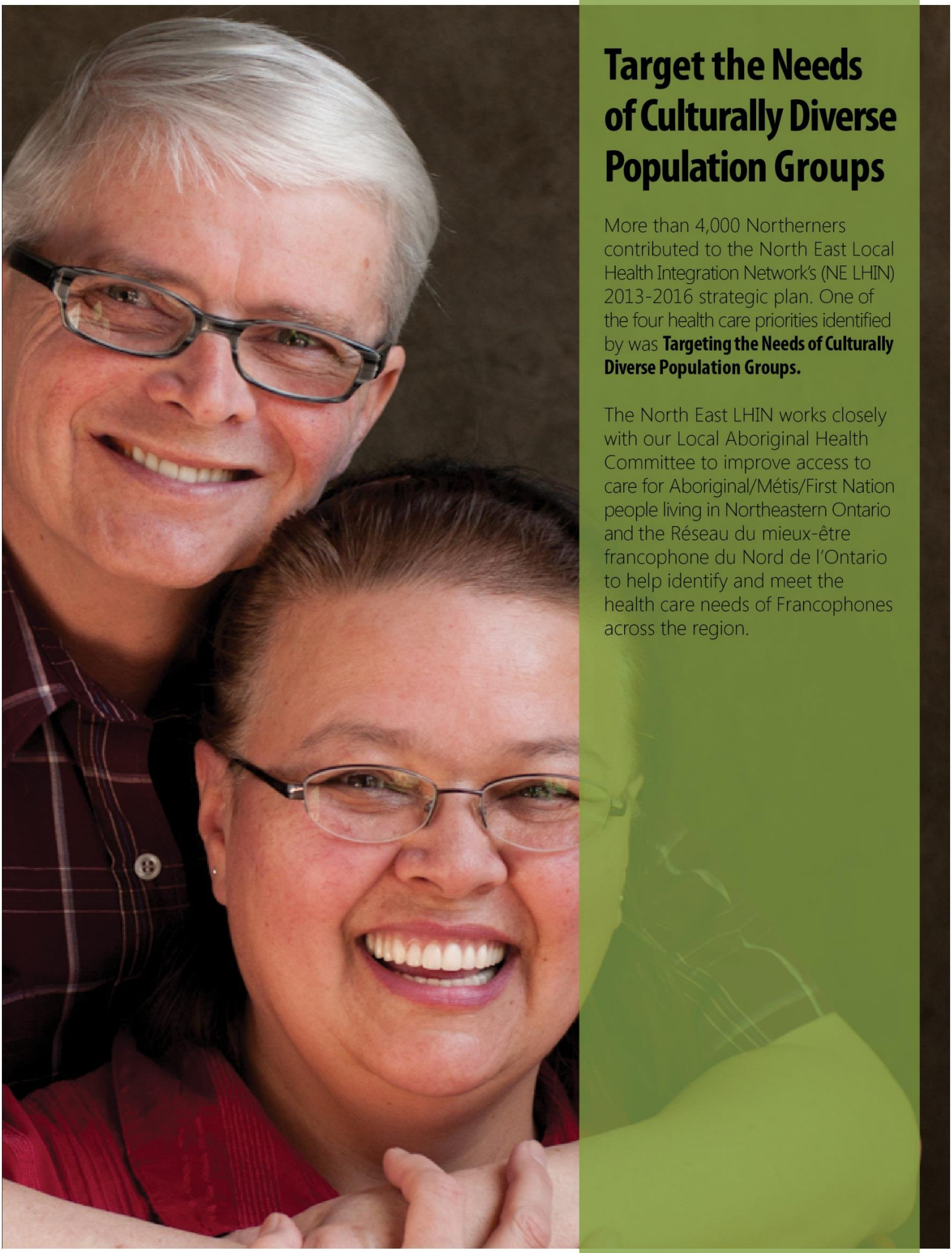
Risks/barriers to successful implementation

- Possible lack of specialized resources.
- Service provision demands on health service providers which could result in processes being slower to implement.
- Some projects are contingent upon multi-ministry/multi-community and community participation.

In light of these potential risks and in an effort to ensure full implementation of these action items over the next three fiscal years, the NE LHIN's mitigation strategy includes: well defined metrics for each initiative, monitoring, and evaluation. Internal LHIN and other system resources will also be garnered to support certain project pieces.

Key enablers

- Increase use of telemedicine services and sites to enhance access to primary care, mental health and addiction and specialty services (psychiatry) and improve equity of access. This will also allow for more frequent training and consultation between mental health and substance abuse treatment professionals.
- The roll-out of realignment plans and the implementation of Health Links will help mental health and substance abuse services to have a positive impact on decreasing readmission rates and provide a more consumer centred approach.
- The launching of the next (4/10) phase of the provincial strategy will inform and enable change.



Target the Needs of Culturally Diverse Population Groups

More than 4,000 Northerners contributed to the North East Local Health Integration Network's (NE LHIN) 2013-2016 strategic plan. One of the four health care priorities identified by was **Targeting the Needs of Culturally Diverse Population Groups.**

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

Aboriginal/First Nation/Métis People

Priority Description

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

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

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

Current Status

The Aboriginal/First Nation/Métis population:

- Conservatively represents 11% of the overall North East LHIN population.
- Is dispersed over a vast geography in urban, rural and isolated remote communities throughout the NE LHIN, including 41 First Nations, and 14 urban and rural communities that speak various Aboriginal languages such as Cree, Ojibwa, and Odawa.
- Have higher rates of chronic disease and co-morbidities and at a younger age than their non-Aboriginal counterparts.
- Continue to have a lower life expectancy, a higher rate of infant mortality, higher rates of suicide and higher rates of infectious disease.
- Have more people who are aging faster than the rest of the population, due to high rates of chronic disease.

The NE LHIN funds 38 Aboriginal health service providers including one hospital, one long term care home, 32 community support service agencies, nine agencies delivering mental health and addiction services, and one community health centre.

The Local Aboriginal Health Committee (LAHC) and the NE LHIN work collaboratively on targeted issues and engagement activities. The LAHC acts as a vehicle for knowledge exchange between the LHIN and Aboriginal health service providers and offers the LHIN on-the-ground intelligence of needs and best practices in Aboriginal health care.

In late February 2013, the NE LHIN facilitated a James and Hudson Bay coastal visit with Dr. Sinha, NE LHIN CEO, two regional geriatricians and the NE LHIN's Primary Care Lead. The 48-hour visit focused on senior care, discussions with community leaders, community members and health facility tours to help understand the challenges in delivering health care services to our most northerly communities. The NE LHIN's response to the discussions was investment in local initiatives (PSW training), resources (foot care kits, transportation van, wheelchair) and a follow up clinical visit with geriatricians and allied health care professionals in January 2014.

During this second visit, a team of specialized care workers conducted assessments of elder residents in Fort Albany and developed individualized care plans. Most recently, the Red Cross implemented a grow-your-own PSW training course to help stabilize the workforce in the area and deliver care in each community. Fifteen individuals have now graduated from the program; ten in Moose Factory and five in Fort Albany.

In the fall of 2013, the NE LHIN funded the North Shore Tribal Council to provide assisted living services under a hub and spoke model to ten high risk seniors in seven First Nation communities along 300 kilometres of the north shore of Algoma. Additional investments include: assisted living for high risk seniors funding to Nipissing First Nation; transportation to Noojmowin Teg on Manitoulin Island creating an additional 120 more trips to 330 clients; supporting Misiway Milopemahtesewin CHC as a key partner in the Timmins Health Link.

Consistency with Government Priorities:						
The identified goals are aligned with key government priorities including: Ontario's Action Plan for Health Care, January 2012, and Living Longer, Living Well, (2012).						
Action Plans	**2014/15**		**2015/16**		**2016/17**	
	Status	%	Status	%	Status	%
Goal 1: Enhance access to health care services that linguistically and culturally appropriate and deemed culturally safe for Aboriginal/First Nation/Métis population.						
Determine the location and number of health service providers (HSPs) who have participated in cultural safety training or are experiencing language barriers and would benefit from training.	In Progress	25%	In Progress	75%	Completed	100%
Work with partners to develop an indicator to include in HSP 2014/15 accountability agreements that measures HSP participation in education of culturally safe services and sharing of best practices.	In Progress	75%	Completed	100%	Completed	100%
Work with providers to determine and implement methods of providing cultural safety training.	In Progress	20%	In Progress	20%	In Progress	20%
Include and monitor indicator in S-AAs.	Not yet started	0%	In Progress	25%	Completed	75%
Goal 2: Increase service coordination, system navigation and access to care for Aboriginal/First Nation/Métis population.						
Formalize partnerships between Aboriginal health service providers and non-Aboriginal providers within and across sectors.	In Progress	20%	In Progress	20%	In Progress	20%
Initiate efforts to collaborate and create protocols between the provincial/federal governments to increase coordination of transportation services.	In Progress	20%	In Progress	20%	In Progress	20%
Monitor and maximize the availability and usage of telemedicine locations and services, particularly for remote and isolated communities.	In Progress	25%	In Progress	25%	In Progress	25%
Goal 3: Increase access to mental health and substance abuse services for Aboriginal/First Nation/Métis population.						
Implement recommendations of the NE LHIN Aboriginal Mental Health and Addiction Strategy with particular attention to traditional healing and cultural treatment methods.	In Progress	10%	In Progress	20%	In Progress	40%
Align Aboriginal/First Nation/Métis mental health and substance abuse treatment services, as outlined in the NE LHIN Mental Health and Addiction strategy decision making framework.	In Progress	20%	In Progress	40%	In Progress	40%

How will we measure success?

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

- Complete inventory of HSPs participating in cultural safety training and/or experiencing language barriers.
- Develop an indicator for service accountability agreements by 2015/16.
- More health service provider participation in linguistic and culturally sensitive training.

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

- Increases in formal partnerships between Aboriginal and non-Aboriginal health service providers.
- More relationships with federal government yielding protocols that result in additional transportation services.
- Increased use of telemedicine locations and services, particularly for remote and isolated communities.

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

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

Risks/barriers to successful implementation

- Vast geography of region and remoteness of some communities pose a challenge to planning strategies and access to health care for Aboriginal people.
- The high degree of health disparities, poverty, low to poor socio-economic conditions and high unemployment are factors that hinder the advancement of Aboriginal peoples' overall health status.
- The multi-level governmental funding to Aboriginal populations, and the complex jurisdictional and governmental relationships that direct First Nation policy, governance and health care delivery.
- The lack of data and baseline information to conduct effective health planning, understand needs and ensure gaps are identified. Comprehensive data collection would allow a greater understanding of the challenges and allow for a more strategic and effective approach to health care.

Key enablers

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

Francophones

Priority Description

For people whose mother tongue is not English, expressing their health care symptoms to a care provider can be a barrier to accessing the health care system. With 23% of the NE LHIN's region Francophone, ensuring equal access to care in a person's language of choice is important.

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

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

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

Current Status

There are 42 health service providers in the North East, across all sectors, which are officially designated under the *French Language Services Act* to provide services in French; two are awaiting their designation; and 60 are working towards the planning and delivery of FLS.

In 2013/2014, two health service providers across the North East were newly designated by the government through an Order-in-Council. Two more requests for FLS designation were approved by the NE LHIN Board, including the NE CCAC and North Bay Regional Health Centre, and these requests are now pending approval at the MOHLTC level.

A new process to evaluate designated health service providers across the region has been drafted and will be aligned with the new provincial strategy developed by the Office of Francophone Affairs. The goal is to ensure that designated providers continue to meet designation criteria and provide quality services in French.

In 2014/2015, the NE LHIN, in collaboration with the French Language Health Planning Entity (FLHPE), will support nine health service providers to complete a FLS designation plan and submission. The NE LHIN's partnership with the entity will continue to help identify and meet the health care needs of Francophones across the North East.

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

- Increased community support services, including day programs and transportation, for Francophone seniors in West Nipissing, Sudbury-East, Greater Sudbury, Chapleau and North Cochrane.
- Increased mental health services for Francophones in Hornepayne through a partnership with a designated provider.

- Temiskaming Health Link has identified its Francophone high users, has captured Francophone patient stories and completed a Value Stream Analysis with Francophone providers.
- The NE LHIN hosted a virtual coffee break with the FLS Commissioner and the ED of the Planning Entity in order to help promote the active offer approach to FLS. Over 80 representatives of health service providers attended the event, which was hosted in both English and French.

Consistency with Government Priorities:

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

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

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

Action Plans	**2014/15**		**2015/16**		**2016/17**	
	Status	%	Status	%	Status	%
Goal 1: Enhance access to primary care services that are linguistically and culturally appropriate.						
Continue to work in partnership with health service providers to increase access to primary care services in French.	Ongoing	100%	Ongoing	100%	Ongoing	100%
Consider and include the needs of Francophones and French-language services in the local planning of primary care, health promotion/prevention and chronic disease services.	Ongoing	100%	Ongoing	100%	Ongoing	100%
Improve service coordination among primary care providers.	In progress	40%	Completed	100%		
Goal 2: Improve system navigation and service coordination across the continuum of care for Francophones.						
Work with regional providers to include the needs of Francophones in local community care planning and to ensure greater access to French-language services.	In progress	80%	Completed	20%		
Increase access to day programs for Francophone seniors, to respite programs for their families, and to transportation programs offering services in French.	In progress	40%	In progress	20%	In progress	20%
Review French language service capacity in long-term care (LTC) homes and increase the number of designated LTC providers.	In progress	40%	In progress	40%	Completed	20%

Goal 3: Increase access to mental health and substance abuse services for Francophones.						
Review the availability of French language services in the mental health and substance abuse sector.	completed	100%				
Increase coordination and integration of mental health and substance abuse services in French.	In progress	20%	In progress	20%	In progress	20%
Continue to work in partnership with providers to increase access to mental health and substance abuse services in French.	In progress	20%	In progress	20%	In progress	20%

How will we measure success?

Increase:

- The use of telemedicine sites to maximize access to care in French.
- Diabetes and other chronic disease programs offer services in French.
- The number of providers designated under the FLS Act from 40 to 45.
- The number of providers who implement active offer guidelines for French language services.
- Access to community support services in French, i.e. day, respite and transportation for seniors.
- The capacity for services in French in long-term care facilities.

Decease:

- Repeat visits to designated hospital ERs for Francophones presenting mental health and substance abuse issues.

Risks/barriers to successful implementation

- HSPs may not achieve expected FLS indicator targets in their acrcountability agreements due to challenges with recruitment and retention of French-speaking staff.
- Due to staff turnover in health service proivders, new staff may not have received the necessary FLS training and education on FLS requirements and active offer.
- Integration activities, especially between providers, must reflect the needs of Francophones as new integrated models of care are implemented (health links, health hubs).

Key enablers

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

Enablers -- Supporting the Successful Achievement of Health Care Priorities

More than 4,000 Northerners contributed to the North East Local Health Integration Network's (NE LHIN) 2013-2016 strategic plan and helped to identify the plan's four priorities.

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

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

Ontario

North East Local Health Integration Network

Réseau local d'intégration des services de santé du Nord-Est

Electronic Health Record Opportunities

The overarching goal of NE LHIN electronic health record efforts is: one patient, one record. This means a single point of access for services, patients tell their story only once, and service providers can securely access and share health information electronically while upholding patient privacy. Electronic health records and ICT (Information & Communication Technology) are key enablers to achieve goals of all LHIN priorities. Technology and information can: support patients to become healthier; provide faster access and a stronger link to family health care; and provide information to the right care, at the right time, in the right place.

ICT solutions are leveraged to support service integration and the delivery of quality patient-focused care. ICT projects reap the greatest benefit when they enhance patient care services or access to services; are part of a broader regional strategic ICT plan; use a multi-LHIN, multi-agency or multi-sector partnership approach; have a sound business case; and are used as foundational elements in the creation of an electronic health record.

Realignment and System Transformation

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

The North East LHIN will continue to work with health care partners to focus care and investments where there is the greatest need; realigning resources to create a truly integrated health care system. The NE LHIN is actively working with partners on achieving the most appropriate model of care for communities, including: health links, health hubs, community networks, and other models.

Recruitment and Retention of Health Human Resources

People working to provide health care services are essential to the transformation of the health care system, whether they are treating people while in hospital, or helping them to transition back home. Greater access to health care professionals helps to promote healthy living and support better management of chronic conditions.

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

With many primary care physicians at or nearing retirement, the NE LHIN has focused its efforts in the past year on better understanding issues related to new physicians taking over existing practices in order to mitigate orphaned patients. The NE LHIN will continue to work closely with: HealthForceOntario, Northern Ontario School of Medicine, and both health and educational partners to advance health human resource strategies and innovative Northern solutions.

LHIN Operations Spending Plan

Template B: LHIN Operations Spending Plan				
LHIN Operations Sub-Category ($)	**2013/14 Forecast**	**2014/15 Allocation**	**2015/16 Planned Expenses**	**2016/17 Planned Expenses**
Salaries and Wages	3,038,540	2,998,459	2,998,459	2,998,459
Employee Benefits				
HOOPP	303,854	299,846	299,846	299,846
Other Benefits	334,239	329,831	329,831	329,831
Total Employee Benefits	***638,093***	***629,677***	***629,677***	***629,677***
Transportation and Communication				
Staff Travel	180,702	175,000	175,000	175,000
Governance Travel	11,383	15,000	15,000	15,000
Communications	76,661	84,000	84,000	84,000
Other	9,355	10,000	10,000	10,000
Total Transportation and Communication	***278,101***	***284,000***	***284,000***	***284,000***
Services				
Accommodation	211,420	177,960	177,960	177,960
Advertising	14,852	10,000	10,000	10,000
Banking	-	-	-	-
Consulting Fees	72,577	35,000	35,000	35,000
Equipment Rentals	13,127	20,000	20,000	20,000
Board Chair Per Diems	10,307	20,000	20,000	20,000
Other Governance Per Diems	15,254	10,000	10,000	10,000
Insurance	4,123	7,500	7,500	7,500
LSSO Shared Costs	241,628	341,520	341,520	341,520
LHIN Collaborative	32,637	47,500	47,500	47,500
Other Meeting Expenses	42,247	50,000	50,000	50,000
Other Governance Costs	11,358	10,000	10,000	10,000
Printing & Translation	54,064	60,000	60,000	60,000
Staff Development	25,662	20,000	20,000	20,000
Total Services	***749,254***	***809,480***	***809,480***	***809,480***
Supplies and Equipment				
IT Equipment	11,323	15,000	15,000	15,000
Office Supplies & Purchased Equipment	37,471	16,166	16,166	16,166
Total Supplies and Equipment	***48,793***	***31,166***	***31,166***	***31,166***
Capital Expenditures	***-***	***-***	***-***	***-***
LHIN Operations: Total Expenses	4,752,782	4,752,782	4,752,782	4,752,782
LHIN Program Expenses				
Diabetes RCC	1,087,560	1,087,560	1,087,560	1,087,560
French Language Services	296,800	296,800	296,800	296,800
eHealth PMO	580,000	510,000	510,000	510,000
Aboriginal Planning	100,000	100,000	100,000	100,000
ER/ALC	100,000	100,000	100,000	100,000
FLS Entity	796,159	796,159	796,159	796,159
Physician Lead	225,000	225,000	225,000	225,000
Grand Total LHIN Expenses	7,938,301	7,868,301	7,868,301	7,868,301
Annual Funding Target	7,938,301	7,868,301	7,868,301	7,868,301
Variance Surplus/(Deficit)	-	-	-	-

LHIN Staffing Plan (Full-Time Equivalents)

Position Title	2013/14 Actual as of March 31/14	2014/15 Forecast	2015/16 Forecast	2016/17 Forecast
Chief Executive Officer	1	1	1	1
Senior Directors	3	3	3	3
Project Coordinators	4	4	4	4
Executive Assistant & Board Liaison	1	1	1	1
Administration Clerk	1	1	1	1
Junior Accountant	1	1	1	1
Human Resources/Corporate Services Coordinator	1	1	1	1
Controller/Corporate Services Manager	1	1	1	1
Analysts – Data, Finance & Performance	2	3	3	3
Senior Advisor, System Performance	1	1	1	1
Director, Communications, Community Engagement	1	1	1	1
Communications & Community Engagement Coordinator	1	1	1	1
Communications Officers	3	3	3	3
Chief Information Officer & eHealth Lead	1	1	1	1
Senior Project Manager	1	1	1	1
Senior Officer, Policy & Health System Planning	1	1	1	1
Hub Officers	4	4	4	4
Outreach Officers	5	5	5	5
Officers – Policy & Health System Planning, Chronic Disease/Diabetes Management, Rehabilitation & Complex Continuing Care, Primary Care, Mental Health & Addictions, Performance & Decision Support, Finance & Performance, Project Management, Long-Term Care	8	9	9	9
French Language Services Officer	1	1	1	1
Aboriginal/First Nations/Métis Officer	1	1	1	1
Total FTEs	**43**	**45**	**45**	**45**

Integrated Communications Strategy

Objectives

Business Objective:
To implement the North East LHIN's 2013-2016 Integrated Health Service Plan and the initiatives contained in this Annual Business Plan to develop a regional system of integrated health care across the continuum – from primary care to public health through to community, acute and long-term care – by:

- Increasing primary care coordination.
- Enhancing care coordination and transitions to improve the patient experience.
- Making mental health & substance abuse services more accessible.
- Targeting the needs of culturally diverse population groups – Aboriginal/First Nation/Métis People
- Explaining the priority enablers: electronic health record opportunities, realignment and system transformation, and recruitment and retention of health human resources.
- Fostering an understanding of the need for health system transformation both internally and externally.
- Building support for the health system model by focusing on the benefits of the health system transformation that creates an integrated sustainable healthcare system that ensures better health, better care, and better value for money.
- Aligning health service providers to help North East LHIN residents through the common direction of "Quality Health Care When Northerners Need It."
- Demonstrating how organizations and individuals can participate in the success of the health system transformation.
- Mitigating communication risks of negative publicity by proactively planning risk reduction.
- Providing information on performance and progress – document successes and share them.

Communications Objectives:

- To build understanding and support regarding the rationale for, and importance of, Ontario's transformation of the health care system.
- To build awareness of the NE LHIN's role in the following priorities and their enablers: improving primary care coordination, enhancing care coordination and transitions to improve the patient experience, making mental health & substance abuse services more accessible, and helping to target the needs of culturally diverse population groups – Aboriginal/First Nation/Métis People.
- To guide the communications and engagement activities of the North East LHIN (Board and staff) and health service provider partners involved in initiatives contained in the 2014/15 Annual Business Plan.
- To ensure that stakeholders understand the role of respective organizations to identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services based on funding available, and to track performance against accountability agreements.
- To provide accurate and timely information to all audiences.
- To be transparent and accountable to our shared audiences re: timelines, outcomes and opportunity for participation/feedback.
- To demonstrate the value of the NE LHIN to people in the NE LHIN region – to help them see themselves in the work we do.

Context

- *Ontario's Action Plan for Health Care*, announced by the Minister in January 2012, which is consistent with the principles of the *Excellent Care for All Act (2010*), puts LHINs at the centre of health system transformation.
- The North East LHIN's "Quality Health Care When Northerners Need It" 2013-2016 IHSP and the initiatives laid out in this Annual Business Plan are strategically aligned with government direction and priorities and recognize the joint accountability of the ministry and LHINs to serve the public interest and effectively oversee the use of public funds.

Target Audience

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

External

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

Internal to the North East LHIN

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

Strategic Approach

Position the NE LHIN as a valued key player within the transformation of Ontario's health system and as the lead in health system transformation in the Northeast region.

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

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

To ensure we are serving persons with disabilities in our region, we will make efforts to communicate and engage with them in a manner, or using facilities, that take these into account.

Key Messages

Ontario is shifting the focus of its health care system to revolve around the person. We have a plan to ensure Ontarians have access to high quality care and a sustainable health system for years to come. By organizing our system differently and focusing on the medical evidence, we will provide Ontarians with better care and better value for tax dollars. Through these changes, we expect to see:

- Reduced wait times and faster access to family doctors
- Fewer unnecessary visits to the emergency room and re-admissions to hospital
- Patients receiving care at home or in the community instead of in a hospital

How are we transforming the health care system?

- Partnering with the sector and enabling them to play an active role in how the system will change.
- Strengthening community agencies to support providers and encourage integration around the patient's needs.
- Health care funding will be determined based on the best evidence and will follow the patient.

What can we expect from these changes to the healthcare system?

- A system built for patients by the health care providers and leaders closest to them.
- A health care system that integrates providers around patients to deliver better outcomes.

By bringing together health care partners such as hospitals and community-based agencies to develop innovative, collaborative solutions that lead to improved access to high-quality care for all residents, the NE LHIN is championing system transformation. LHINs have a critical role to play in key provincial initiatives such as Health System Funding Reform, Health Links, Seniors' Strategy and the expansion of Quality Improvement Plans into the primary and community care sectors.

Guided by its 2013-2016 strategic plan, the *Integrated Health Service Plan*, the NE LHIN is collaborating with health care sector partners to organize the system differently and focus on medical evidence to bring about significant and positive change to ensure reduced wait times and faster access to family doctors, fewer unnecessary visits to the emergency room and readmissions to hospital, and patients receiving care at home or in the community instead of hospital.

The NE LHIN is working with our health care partners to address the health profile realities of our regional population – aging and with rising rates of chronic conditions – to enhance care coordination and transitions to improve the care experience.

- We are working respectfully with our culturally diverse population groups to target their health care needs.
- The NE LHIN believes everyone has an important role to play in making healthy change happen, including health-service providers, the LHINs, community leaders and the public (including patients/clients).

Tactics

To be referenced in each plan but will include:

- News releases/blast emails/newsletters/bulletins
- Website postings/alerts/social media
- Stakeholder events
- Outreach to local government stakeholders
- Engagement with specific stakeholders – provincial associations, community groups, etc.
- Organizing and participating in information sharing events
- Board Meetings

Evaluation

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

- Comprehensive monthly media tracking analysis to measure success through output (what efforts were made), outcomes (results of those efforts), and impact (including the NE LHIN's ability to influence transformation, progress with Ontario's Action Plan, and Dr. Sinha's Seniors Strategy).
- The LHIN's ability to make quick modifications based on shifts and lessons learned as activities are carried out – including response by social media and traditional media.
- Visible senior leadership engagement and support of the ABP initiatives and related communications.
- Key stakeholders have a clear understanding of the "*Quality Health Care When Northerners Need It*" transformation agenda and how they will be impacted by the implementation of any related initiatives. At each engagement opportunity, feedback will track success and/or determine needed modification of information dissemination and comprehension.
- Health care providers across the North East LHIN are engaged early and frequently and can see how their participation is impacting implementation/transformation. Evaluation following engagements track progress in this regard.
- People in the North East LHIN region are engaged by the LHIN and with the LHIN via a variety of tactics including traditional media, online/social media (e.g., websites, Twitter), and LHIN communication vehicles (blast emails, bulletins).

Community Engagement

Community Engagement

Guided by the organization's vision "Quality health care, when Northerners need it" and focused on achieving its identified priorities in 2014/15, the North East LHIN will fulfil its commitment to community engagement in the following ways:

Engagement Strategies and Best Practices

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

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

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

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

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

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

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

Keeping Public Stakeholders Engaged and Informed

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

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

NE LHIN Engagements

Throughout the year, the NE LHIN will hold engagements with both fellow Northerners and health service providers which includes, but is not limited to:

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

Evaluation

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

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

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