North East **LHIN**
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NORTH EAST LOCAL HEALTH INTEGRATION NETWORK

Annual Business Plan 2011/12

May 31, 2011

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

Annual Business Plan 2011/12

CONTEXT

TRANSMITTAL LETTER FROM NE LHIN BOARD CHAIR

May 31, 2011

Alexander Bezzina
Assistant Deputy Minister
Health System Accountability and Planning Division
Ministry of Health and Long-Term Care

Dear Assistant Deputy Minister Bezzina,

The North East Local Health Integration Network (NE LHIN) is pleased to provide you with our 2011/12 Annual Business Plan (ABP) as required by the Local Health System Integration Act, 2006, the Ministry/LHIN Memorandum of Understanding, and the Ministry/LHIN Performance Agreement (MLPA).

The 2011/12 ABP provides details on the current status and action plans to achieve the goals of our nine IHSP priorities for 2010-13. Integration is critical to our success as we explore and implement opportunities with our region's 186 health service providers.

The NE LHIN has completed two significant hospital integrations. In 2010/11, WAHA was created by integrating the Federal and Provincial hospitals in the James and Hudson Bay Coast. We began 2011/12 with the voluntary integration of North Bay General Hospital and the North East Mental Health Centre into one hospital corporation. The Multi Sector Accountability Agreements (MSAA) presented another opportunity for integration. During this process the NE LHIN was able to reduce the total number of MSAAs from 132 to 119. As we proceed with our community engagement sessions this spring and summer, we will apply the lessons-learned from these integrations, as well as the current project to integrate of 18 mental health and addiction agencies in the Algoma area, to identify new initiatives for integration in Northeastern Ontario.

The NE LHIN weekly census report confirms that we have been successful in reducing the percentage of ALC days from 25% in March 2010 to 19% as of March 2011. We are moving from a system focused on institutional care – mainly centered on hospitals – to one that is more community based. This realignment includes:

- Reducing the demands on hospitals by investing in community;
- Improving the way patients are seen and cared for in hospital from emergency department to discharge; and
- Managing our community capacity both in terms of human resources and physical resources.

ALC continues to be our LHIN's top priority and we will continue to educate and inform the public, work with local community partners to address systemic issues, and ensure timely and appropriate placement of ALC patients within our communities. We are also committed to working with the Ministry to develop solutions and invest in the necessary infrastructure and community supports to tackle the ALC issue and free up needed acute care resources to provide patients with the right care, at the right time, in the right place, and the right cost.

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

Sincerely,

Peter Vaudry
Interim Board Chair

MANDATE AND STRATEGIC DIRECTIONS

The NE LHIN vision of ***'health and wellness for all'*** was created with the goal that quality healthcare must be delivered to *all* people residing within the NE LHIN region. In order to fulfil this vision, the NE LHIN developed and embraced a mission statement of creating an ***'innovative, sustainable and accountable'*** health care system in Northeastern Ontario.

This NE LHIN vision and mission align with the Ministry's strategic directions as outlined in its 2010/11 operational plan:

- Healthier people;
- Healthier communities; and a
- Healthier system.

Our mission and vision also aligns well with the Ministry's stated strategic objectives and is specifically referred to in our Integrated Health Service Plan (IHSP):

- ER Service Improvement;
- ALC reduction;
- Diabetes service improvement;
- Mental Health and Addictions service improvement; and
- eHealth.

A key component to help achieve the NE LHIN's vision is our ***Integration Strategy.*** This Strategy was built upon the need to appropriately plan and make the necessary system and service level adjustments that:

- Enhance access and quality of health services;
- Improve individual and population health outcomes;
- Improve the overall patient experience within the health system by reducing fragmentation and duplication; and
- Realize greater efficiencies through the most effective use of available resources.

The fulfillment of the NE LHIN vision relies on the shared responsibility to deliver quality health care programs and services across Northeastern Ontario. An integrated, patient-focused health care system will only be realized when all health service providers and community organizations work together. In 2011, the NE LHIN will continue to strengthen its partnerships through concerted engagement and education efforts in order to achieve an even more cohesive understanding of ***health and wellness for all.***

The NE LHIN will continue to be lead a number of voluntary integration activities to generate a more patient-focussed and sustainable local health care system. . Patient-focused integration efforts will allow for an easier health care system for people to navigate and a greater possibility to maintain or enhance current service levels.

OVERVIEW OF CURRENT AND PLANNED PROGRAMS/ACTIVITIES

The nine priorities outlined in the 2010/2013 Integrated Health Service Plan (IHSP) of the NE LHIN are interrelated and are not independent of one another. The priorities are regionally focused; however their management is important to the rising tide of improved health services across the province. The implementation of these priorities will be approached through innovations in information and communication technology and electronic processes (eHealth).

The NE LHIN priorities identified in our current IHSP can in fact be grouped as follows:

(1) Alternate Level of Care Strategies and Solutions

- *Emergency Department Wait Times*
- *Aging at Home*

(2) An Integrated Approach to Cultural Diversity

- *Aboriginal/First Nations/Métis Health Services*
- *French Language Health Services*

(3) Addiction and Mental Health Services
Developing a more integrated system to help address addiction and mental health needs of individuals and communities across the region

(4) Diabetes Care
Identifying and planning local diabetes initiatives that support the goal of self-management for those people living with diabetes in Northeastern Ontario

(5) Health Human Resources
Engaging with local health service providers, communities and individuals to determine innovative ways to use our current workforce and attract and retain additional professionals for Northeastern Ontario

(6) Optimize Surgical Services
Ensuring equitable access to surgical services across the region

Integration and eHealth are processes of change necessary for a more patient-focused and efficient health system of care. (*Although eHealth and Integration are not stand-alone IHSP priorities, for the purpose of this ABP, a Template A (Core Content) in Section 5 has been completed for these two items given their significance in the overall work of the NE LHIN.)*

IHSP Priorities:

Alternate Level of Care Strategies and Solutions

Comparing LHIN regions, the per cent of hospital beds occupied by ALC patients is one of the highest in Northeastern Ontario. The current ALC pressures of the region are untenable and remain a priority for all community leaders who are committed to introducing new solutions. The goal of the NE LHIN is to demonstrate a sustained reduction in ALC in acute care over the next three years by implementing initiatives such as resource/capacity strategies, improving processes of care delivery, and performance monitoring.

In addition to its partnership with health service providers and the NE CCAC, the NE LHIN is committed to working with local municipalities, primary care providers, long-term care providers and other community partners in addressing ALC challenges.

Provincially, the NE LHIN is working with its LHIN partners on the eight LHIN High Priority Projects that were agreed to provincially as a result of the September 2010 Stocktake meeting: Excellent Care for All Act; Home First; Senior Friendly Hospitals Strategy; Provincial Falls Prevention Program; Rehabilitation and Complex Continuing Care Expert Panel; Reduction of ALC within 2 Days; Resource Matching and Referral; and Access to Care – Improving Accuracy of ED/ALC Data.

The NE LHIN is also one of four LHINs that completed the ALC Patient Flow Improvement Pilot Project sponsored by the Ministry of Health and Long-Term Care. The project supported the development of solutions that will address long stay ALC patients and immediate needs for alternative housing. The NE LHIN will be implementing the strategies identified in the project in Sudbury and Sault Ste Marie.

Emergency Department (ED) Wait Times

The goal of the NE LHIN is to reduce the number of non-urgent and less-urgent visits to emergency departments and to continue to improve ED wait times and patient satisfaction in the NE LHIN. The following actions/outcomes have been planned for the next three years:

- Develop e-referral and resource matching to expedite patient referrals out of acute care and divert ED visits; a wait time information system to provide detailed information about waits for post-acute care; and an ED reporting system to capture information on hospital ED length of stay to facilitate performance management.
- Ensure appropriate utilization of hospital beds and resources.
- Improve capacity management including surgical flow.
- Ensure that community services are available to enable patients, wherever possible, to avoid visiting the ED.
- Expand community-based projects to manage selected chronic diseases.
- Support comprehensive performance improvement training with respect to ED patient flow.
- Increase case management and system navigation.
- Support the NE LHIN's Emergency Department Network (that will address, among other things, a coordinated coverage plan for all 27 EDs in Northeastern Ontario).
- Improve triage and admission processes.
- Implement strategies to reduce ALC pressures.

Aging at Home (AAH)

The main focus for Year 3 was to enhance community services for seniors and to address ER wait times and ALC pressures. In line with the provincial direction to address ER wait times and ALC pressures, the NE LHIN will focus on the frail elderly, particularly the low income, within each of the following four priorities:

- Implement the North East Home First Strategy starting in the four large HUB hospitals and subsequent roll out to the remaining 20 hospitals in the region
- Expand the North East Specialized Geriatric Services

- Establish interim and permanent long-term care beds and assess/restore beds
- Develop seniors' assisted living capacity

In 2011/12, the NE LHIN will continue to monitor the investments from all three years of the AAH Strategy to ensure that they are continuing to contribute to relieving ED/ALC challenges across the region.

An Integrated Approach to Cultural Diversity

Aboriginal/First Nation/Métis Health Services

The NE LHIN will continue to work towards improving the health status of Aboriginal/First Nations/Métis people across Northeastern Ontario. The NE LHIN supports Aboriginal health services that align with existing Aboriginal/First Nations/Métis regional, provincial and federal health planning, program and service delivery structures to improve health outcomes.

French Language Health Services (FLHS)

Community consultations for the purpose of validating the priorities in the IHSP indicated that an integrated approach to addressing challenges for the Francophone community is required. Effective engagement with Francophone stakeholders will continue both internally with the French Language Services team of the NE LHIN and externally with the recent announcement and signed agreement with the new French Language Health Planning Entity (FLHPE). The NE LHIN integrates FLHS within each priority and within its mission and vision. The following three main objectives will guide French language planning activities in 2011-2012:

- Continuous improvement in the quality, accessibility and integration of FLHS
- Community empowerment and continued community engagement with the Francophone community with the support, assistance and guidance of the new FLHPE in order to impact the overall health system and improve health status
- Accountability of health service providers to their community.

Addictions and Mental Health Services

The NE LHIN will help to implement the provincial mental health and addictions strategy, to create a system that provides people who need care with equitable access to safe, respectful and effective services. In order to achieve this objective, the NE LHIN will develop a more integrated system in Northeastern Ontario to help address the needs of individuals and communities across the region. An integrated system also has the potential to create better links with other key areas such as housing, income, employment, and social supports that are important components to providing a comprehensive approach to mental health and addiction treatment and support. For example, in Algoma, we will are working to establish an integrated addiction and mental health 'Anchor Agency' over the next two years. This innovative model of bringing 129 services from 13 different agencies together will be monitored closely for opportunities to be applied to other regions and sectors within the NE LHIN. The NE LHIN will also work with the MOHLTC to implement services identified within the 10 year strategic direction with an initial focus on transitional aged youth, eating disorders, early identification initiatives, addictions subsidized housing and system navigation.

Diabetes Care

According to a report released in October 2007, the prevalence of diabetes is significantly higher in the NE LHIN compared to the rest of the province. The report indicated that

compared to provincial rates, the NE LHIN has significantly higher rates associated with diabetes for:

- in-patient hospital discharge;
- mortality; and
- emergency department visits.

The NE LHIN will support the provincial Diabetes Strategy to help increase access to integrated diabetes care and education programs.

The NE LHIN has two goals for diabetes care: (1) identify and plan local diabetes initiatives in the NE LHIN; (2) support self-management for those people living with diabetes.

Health Human Resources (HHR)

Each of the IHSP priorities has a human resource dimension. The NE LHIN will work with the province, Healthforce Ontario, local health service providers, communities and individuals to determine innovative ways to utilize our current workforce and attract and retain additional professionals to the region. We will engage with stakeholders to create a system-wide framework to anticipate HHR requirements and mitigate service delivery challenges as they pertain to Northeastern Ontario's health care workforce.

Optimize Surgical Services

Aligned with the provincial focus and as a result of discussions with key stakeholders from across Northeastern Ontario, the NE LHIN undertook a review of surgical services being delivered in hospitals across the region to ensure access and quality of care could be maintained in the future. A Surgical Optimization Steering Committee was established to manage the project. The first phase of the project is now complete and the Steering Committee is moving forward with a three-year action plan. The following are the immediate priorities of the Committee:

- thoracic surgical oncology;
- orthopaedic, as it relates to hip and knee replacement; and
- call schedule for urgent/emergent surgical care.

eHealth

eHealth and specifically information and communication technology (ICT) solutions are key enablers for each of our IHSP priorities. ICT will be leveraged to support service integration and the delivery of quality care. The NE LHIN will be working on deploying the eHealth strategic plan that was developed in consultation with health service providers, eHealth Ontario and in alignment with our IHSP.

Integration

The NE LHIN supports integration initiatives that demonstrate action, priority setting and coordinated health service planning. In the summer of 2011, the NE LHIN will be holding more than 20 community engagements. The purpose is to identify additional opportunities for integration and to ensure NE LHIN investments are aligned with local health care needs. The following are examples of some integrations the NE LHIN is currently working on in partnership with our health service providers:

- The creation of an Anchor Agency in Algoma to integrate 129 mental health and addiction services currently administered by 13 providers. It is expected that the agency will provide easier access to services for consumers and their families. The NE LHIN will be monitoring the creation of the model closely and anticipates that the learning may be applied to adopt similar models of integration across the region.

- The voluntary transfer of the Esprit Place Sexual Assault Program from the District of Parry Sound Social Service Administration board to the Muskoka/Parry Sound Coordinated Sexual Assault Services. Once approved by the NE LHIN, this integration will result in a more streamlined approach to delivering sexual assault programs in Parry Sound.

ASSESSMENT OF ISSUES FACING THE NE LHIN (ENVIRONMENTAL SCAN OF OPPORTUNITIES AND RISKS)

Our Population

The NE LHIN covers a large geographic area of approximately 400,000 square kilometres. With a 2006 population of 551,691 persons, the overall population density in the region is only 1.4 persons per square kilometre. When compared to the provincial population density of 13.4 persons per sq km (Southern Ontario has a population density of approximately 100 persons per sq km), it is not surprising that there are significant challenges to providing health care in Northeastern Ontario.

According to the Statistics Canada 2006 Census, the NE LHIN has:

- a much higher proportion of Aboriginals than Ontario as a whole – 9.4% and 2.0% respectively;
- a significantly higher proportion of Francophones compared to Ontario – 22.7% and 4.0% respectively;
- an older population than the province as a whole (16.5% of NE LHIN is aged 65 and over compared to 13.6% in Ontario);
    - the Aged Dependency Ratio (the per cent of people 65+ relative to working age group 15-64) is 24.5% in Northeastern Ontario *vs.* the province's Aged Dependency Ratio of 19.9%
- an overall lower education status than the rest of the province;
    - only 50.3% of the population in Northeastern Ontario aged (25+) have a postsecondary certificate, diploma or degree *vs.* the provincial rate of 56.8%
    - 25.9% of the population in Northeastern Ontario (age 25+) have no certificate, diploma, or degree *vs.* the provincial rate of 18.7%.
- a lower employment status;
    - an overall unemployment rate in the NE LHIN which is higher than the provincial rate, 8.4% vs. 6.4% respectively;
    - a participation rate (the per cent of the population in the labour force) which is lower than Ontario's, 60.1% vs. 67.1% respectively.

Additionally, the NE LHIN has seen a population reduction of 0.3% from 2001 to 2006, whereas Ontario has seen a population increase of 13.1%. These geographic, demographic and socioeconomic realities are only some of the challenges to those providing health care in Northeastern Ontario.

NE LHIN Population Health Status

The Statistics Canada 2010 Health Profile (Statistics Canada, Canadian Community Health Survey, 2009) reports that there is a smaller proportion of NE LHIN residents who report their health as 'very good' or 'excellent' compared to Ontarians overall. Also, the profile shows a higher prevalence of self-reported activity limitation in the NE LHIN compared to Ontario - 34.8% vs. 27.8% - and a higher proportion of persons who report pain or discomfort preventing activities - 17.4% vs. 13.2%.

Furthermore, the NE LHIN has higher percentages of people whose health practices are known to compromise health status when compared to Ontario. These include:

- daily smokers - 20.2% vs. 14.4% - and exposure to second hand smoke at home - 7.6% vs. 5.3%;
- adults who are current drinkers reporting heavy drinking - 18.6% vs. 15.6%; and
- adults who are obese - 26.5% vs. 17.4%.

Not surprisingly, the health profile also shows a higher prevalence of chronic diseases in the NE LHIN, including:

- arthritis/rheumatism - 24.0% vs.16.8%;
- asthma - 10.0% vs. 8.2%;
- high blood pressure - 23.% vs. 17.2%;
- diabetes - 7.2% vs. 6.4%; and
- hospitalized acute myocardial infarction event rate - 314 vs. 216 per 100,000 people.

In addition, the profile indicates a lower rate of contact with a medical doctor in the previous 12 months in the NE LHIN - 79.7% vs. 82.9%; and a smaller proportion or persons who report having a medical doctor - 86.0% vs. 91.5%. The proportion of the population with a family physician is significantly lower than the provincial average (Access to Primary Care in Ontario: 2009; Health Analytics Branch, Health System Information Management and Investment Division September 2010).

Mortality, Potential Years of Life Lost, and Hospitalization

An analysis by MOHLTC-Health Analytics (previously the Health System Intelligence Project) of age-standardized mortality (2000/2001 average) and hospitalization rates (2003/2004), as well as rates for potential years of life lost (PYLL[1]) by ICD-10 chapter (2000/2001 average), for the years is also quite revealing. The analysis indicates that, in the NE LHIN:

- PYLL are significantly higher than provincial rates for all causes, and select causes including Respiratory system diseases, Circulatory system diseases, Neoplasms overall and Malignant Neoplasms specifically.
- All-causes age-standardized mortality ratio (ASMR), as well as ASMRs for circulatory system diseases, respiratory system diseases, and neoplasms are all significantly higher than their respective provincial rates. The leading causes of mortality in Northeastern Ontario are circulatory disease (245.3/100,000) followed by neoplasms [cancer] (203.9/100,000).
- Life expectancy at birth for males and females is significantly lower compared to Ontario (2001).
- Hospitalization rates for all ICD-10 chapters in 2003-04 are higher relative to the province as a whole.

The high prevalence of chronic heart conditions - as evidenced by the CCHS and MOHLTC reports and data - naturally places a burden on the health care system in the NE LHIN, in turn reducing the quality of life for those who suffer from the condition.

Health System Performance

There are a number of health system performance indicators that are measured in Ontario including Alternate Level of Care (ALC) days, Median Time to Placement to LTC, Emergency Department Performance Indicators, Ambulatory Care Sensitive Conditions (ACSC) -

[1] Potential Years of Life Lost (PYLL) rates are useful for quantifying the number of years of life "lost" from deaths that occur "prematurely" (i.e. before age 75)

conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital, and wait times for select procedures.

1. Alternate Level of Care (ALC) days measured as a proportion of total in-patient days for Q3 2010/11 in the NE LHIN was reported as 31.0% vs. 16.3% for Ontario overall. The Northeastern proportion of ALC days was the highest reported value and the ALOS of ALC patients in Northeastern Ontario was the highest value reported provincially. There are many causes for the ALC problem in the NE LHIN ranging from higher hospitalization rates to lack of destination capacity for patients requiring placement.

2. At Q4 2010/11 the Proportion of Admitted patients treated within the LOS target of ≤ 8 hours was 53% vs. 39% for Ontario. The proportion of non-admitted high acuity (CTAS I-III) patients treated within their respective targets of ≤ 8 hours was 90% vs. 91% for Ontario. The proportion of non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of ≤ 4 hour was 87% vs. 86%.

3. The Ambulatory Care Sensitive Conditions (ACSC) measure is an age-standardized rate per 100,000 people under age 75 years. The NE LHIN rate for fiscal 2009/10 was the highest in the province at 679 per 100,000 people, and much higher than the provincial rate of 330 per 100,000.

4. Wait times in days for select procedures in the NE LHIN compared to Ontario (fiscal 2010/11) are shown in the following table:

90th Percentile Wait Times for Access Indicators, NE LHIN and Ontario for fiscal 2010/11

Procedure	NE LHIN Wait Time in Days 90th percentile	Ontario Wait Time in Days 90th percentile
Cardiac By-Pass Procedure	62	49
Cancer Surgery	62	60
Cataract Surgery	125	123
Hip Replacement	301	181
Knee Replacement	426	197
Diagnostic MRI Scan	105	116
Diagnostic CT Scan	33	33

Source. Directory of Networks (DoN), MOHLTC, posted May 13, 2011. "MLAA-PIs Reported Data FY 2011/11 (May 13, 2011) Final.xls" N.B. Values represent actual days for fiscal 2010/11; they do not indicate Ontario Benchmark, LHIN Base Lines or LHIN Targets.

New/Emerging/Evolving Drivers of System Change

Age Structure

Beyond the current difference in age structure between the NE LHIN and the province overall, it is important to consider that the projected difference in the near future will be greater still. For example, the 2009 population estimates (Ministry of Finance) assess the proportion of the NE LHIN population aged 65+ at 17.0% compared to 13.7% in Ontario, a difference of 3.3%. However, the proportion of persons aged 65+ in the NE LHIN projected for the year 2016 is 20.5% compared to 16.0% for Ontario. This gap of 4.5% is expected to grow.

For the NE LHIN, this aging population will translate to a higher:

- rate of chronic diseases (with associated co-morbidity);
- demand for many health services;
- demand for long-term care; and
- demand for Aging at Home opportunities.

Aboriginal/First Nation/Métis Population Growth

Given the larger proportion of Aboriginal/First Nation/Métis in the NE LHIN (9.4%), it is important to consider the unique population structure associated with this population and the impact it may have as a key driver of change.

In Canada, the Aboriginal population is younger and has a much higher fertility rate than the non-Aboriginal population. This is significant because evidence shows that in the Hudson and James Bay Coast area, incidence rates are high and resource issues are significant for: sexually transmitted diseases; injuries and poisonings; infant mortality and pregnancy complications; and teenage pregnancies.

Furthermore, First Nations youth are more likely to die of suicide than the general population, with a significant proportion of teen deaths attributable to suicide.

According to Health Canada, compared to the general Canadian population, First Nations people have a higher risk of:

- Type 2 Diabetes;
- HIV and AIDS; and
- Tuberculosis.

Health Canada also reports that, in the year 2000, life expectancy at birth for the registered Indian population was estimated at 68.9 years for males and 76.6 years for females. This reflects differences of 8.1 years and 5.5 years, respectively, from the 2001 Canadian population life expectancies.

A ‘patient-centered care’ health system demands investments and strategies to eliminate these health disparities.

North East Resource Based Economy as a Determinant of Health

Employment and generated income are key contributors to health status. Unfortunately, the recent global economic downturn has had a significant negative impact on many of the resource based industries (including forestry and mining) on which Northeastern Ontario depends. Employment in these industries is significantly greater in the NE LHIN (7.3%) compared to the province overall (2.9%). Recovery continues to be slow and it is expected that increased unemployment and poverty rates will ultimately contribute to negative health outcomes among NE LHIN residents.

Trends in Performance Indicators in the NE LHIN

The following section outlines the most recent available trends in measured performance indicators. This section will focus on the Ministry-LHIN Performance Agreement (MLPA) indicators in order to highlight the potential emerging drivers of system change in the NE LHIN.

Emergency Department and Alternate Level of Care

The NE LHIN's 2010/11 performance for both percentage of ALC days and emergency department indicators are trending unfavourably and are not meeting the NE LHIN Target for 2010/11. Table 1 below summarizes these results. The NE LHIN continues to experience challenges in placing ALC patients, particularly those who are waiting to be placed in long-term care (LTC). This ALC challenge consequently creates a backlog of patients in the ED making it difficult to meet performance targets. North Bay and Timmins hospitals were very successful with the projects they implemented to improve the ER wait times. Both hospitals received bonus funding for their achievements. Two large urban hospitals (Sudbury and Sault Ste. Marie) have been in over-capacity for weeks at a time with occupancy exceeding 100% and admissions to the emergency department inhibiting patient flow.

Table 1. MLPA Performance Variation MLPA – ER/ALC

Performance Indicator	Provincial Target	NE LHIN Target	Baseline 2009/10	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11	Trend
Percentage ALC Days	9.5%	17.0%	28.0%	34.1%	34.1%	31.1%	Not yet available	▲
90th percentile (Emergency Room) ER Length of Stay for Admitted Patients	25.0	20.7	21.8	27.1	28.9	28.8	29.1	▲
90th percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	7.0	6.5	6.9	6.9	7.1	6.9	7.9	▲
90th percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4.0	4.0	4.3	4.2	4.3	4.3	4.4	▲

1. Preliminary Results

The NE LHIN tracks ALC days each week using a modified methodology that demonstrates accumulated ALC days weekly. This approach differs from the provincial data which is based on quarterly discharge data. The NE LHIN commenced its tracking in December 2010. Local data demonstrate that the percentage of ALC days in acute care has decreased from 25% in January 2011 to 19% at the end of March 2011 for the four large urban hospitals. Rural hospital rates decreased from 31 to 28%, and across all NE LHIN hospitals the rate has decreased from 25 to 21%.

The NE LHIN embarked (Sept. and Nov. 2010) on the creation of additional temporary bed capacity including Assess/Restore beds in two communities with high ALC challenges (Sault Ste. Marie and Sudbury). Preliminary results in Sault Ste. Marie are indicating a decrease in the number of ALC patients in acute beds. The roll-out of Home First in four large hospital communities and Home First/Integrated Discharge Planning is implemented in these hospitals. A new long-term care facility opened in

Sudbury in March/April 2011 and licensing and funding for additional interim short stay beds will be in place in Q1 2011/12, which will contribute to reducing ALC pressures.

Mental Health and Addiction

The NE LHIN's most recent mental health and addiction performance indicators show an increase in repeat unplanned emergency visits within 30 days for mental health and substance abuse conditions. Table 2 below summarizes these results.

Table 2. MLPA Other – Repeat Avoidable ER Visits for Mental Health and Substance Abuse

Performance Indicator	Provincial Target	NE LHIN Target 2010/11	Baseline (2008/09 Q3-Q4 &2009/10 Q1-Q2)	Q3 2009/10	Q4 2009/10	Q1 2010/11	Q2 2010/11	Trend
Repeat unplanned emergency visits within 30 days for mental health conditions	17.1%	14.8%	16.0%	16.6%	18.1%	17.5%	18.9%	▲
Repeat unplanned emergency visits within 30 days for substance abuse conditions	25.8%	19.0%	20.6%	24.6%	23.5%	24.9%	29.2%	▲

Mental health and addictions agencies in the NE LHIN have developed plans to implement strategies to decrease unscheduled revisits to the ER. The NE LHIN is reviewing the plans to determine which strategies can be implemented regionally and quickly to help reduce the repeat visits. The expectation is to have more consumers report to alternative community programs when experiencing a crisis, thereby diverting this patient by early consumer support.

Excellent Care for All

The NE LHIN's most recent performance in 30 day readmission rates for selected CMGs (Case Mix Groups) shows an increase since Q1 2010/11. Table 3 below summarizes these results.

Table 3. MLPA Other – Reduce Avoidable Hospital Readmission

Performance Indicator	Provincial Target	NE LHIN Target 2010/11	Baseline 2008/09	Q4 2009/10	Q1 2010/11	Q2 2010/11	Trend
30 day readmission rates for selected CMGs (Case Mix Groups)	14.7%	14.4%	16.6%	16.1%	16.3%	17.4%	▲

A number of IHSP priorities will help address performance on this indicator, in particular the development and implementation of the Ontario Diabetes Strategy. Additionally, enhanced access to primary care (per the recent announcement of 3 new NPLCs and 6 new FHTs for the NE LHIN) will help to address a reliance on hospitals in many communities. Evidence-based CHF, COPD and diabetes wound care pathways and ambulatory care clinics are under development in Sudbury. Once established, the NE LHIN will promote their roll-out to other communities.

Surgical and Diagnostic Wait Times

The NE LHIN's most recent performance in surgical and diagnostic wait times generally shows an unfavourable upward trend with the exception of cardiac by-pass procedures and diagnostic CT scan. Table 4 below summarizes these results.

Table 4. MLPA Other – Reduce Surgical and Diagnostic Imaging Wait Times

Performance Indicator	Provincial Target	NE LHIN Target 2010/11	Baseline 2009/10	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11	Trend
90th Percentile Wait Times for Cancer Surgery	84	48	51	61	67	54	63	▲
90th Percentile Wait Times for Cataract Surgery	182	115	115	105	121	133	141	▲
90th Percentile Wait Times for Cardiac By-Pass Procedures	84	49	49	105	27	49	28	▼
90th Percentile Wait Times for Hip Replacement	182	300	386	233	365	301	302	▼
90th Percentile Wait Times for Knee Replacement	182	300	382	378	449	409	414	▼
90th Percentile Wait Time for Diagnostic MRI Scan	28	69	69	91	102	112	122	▲
90th Percentile Wait Times for Diagnostic CT Scan	28	29	29	36	35	31	30	▼

Cancer Surgery

The wait time for Cancer Surgery increased by Q4 2010/11 and is above the NE LHIN target but remains markedly below the provincial target. Moves to new hospital sites in two large urban communities contributed to increased wait times in Q4 2010/11.

Cataract Surgery

The unfavourable performance is related to hospitals exceeding their targeted volume, limiting the number of cataract procedures being done due to funding constraints to address wait times. Without additional volume it is unlikely significant improvements will be seen in future quarters for cataract wait time. The NE LHIN is still below the

provincial target of 182 days. Cataract volume allocations for 2011/12 are less than 2010/11, which will add increased pressure on wait times by the end of 2011/12.

Cardiac By-Pass Procedures

Sudbury Regional Hospital is the only hospital in the region performing cardiac by-pass surgery. In late 2009/10 Sudbury moved to a new single site hospital which is now fully operational. This move created the unfavourable performance in 2010/11 Q1 which has resolved in subsequent quarters. Sudbury's performance at Q4 2010/11 is 28 days which is the second best in the province.

Hip Replacement

Additional cases through the intra-LHIN re-allocation process in Q4 2010/11 assisted in the reduction of wait times for hip replacements in the NE LHIN. The NE LHIN Hip and Knee Replacement Program will include a Central Registry (by 2010/11 Q4) and five Joint Assessment Centres (JACs) by 2011/12 Q1. The JACs assist in patient flow and reducing wait times. Success shown in Sudbury with the implementation of the JAC will be replicated at the additional four sites in the NE LHIN.

Knee Replacement

Wait times for knee replacement remain high in the NE LHIN due to surgical capacity issues. Aggressive recruitment initiatives in both North Bay and Timmins are anticipated to bring much needed surgical expertise to the NE LHIN by Q2 and Q3 2011/12. In addition, patient surgeon preference is also a factor contributing to wait times in two NE LHIN communities. The NE LHIN has, for the second year, completed all of their wait time volumes and has capacity to do more surgeries. The implementation of the Central Registry will enable residents of the NE LHIN to receive surgical services in a community outside their own and will contribute to reducing wait times. The Joint Assessment Centres are providing timely assessments and identification of surgical candidates across the NE LHIN.

Diagnostic MRI Scan

The unfavourable performance is related to increased demand for MRI services combined with hospitals reaching operational capacity. In order to reduce MRI wait times, hospitals will have to increase MRI hours. The NE LHIN has been allocated additional MRI hours for 2011/12 and the opening of the first MRI in North Bay with base and incremental hours will have a positive impact on wait times for MRI by Q2 2011/12. However, local diagnostic experts also report on the increasing demand for MRI due to physician diagnostic requisitions.

Diagnostic CT Scan

Wait times for CT scans remain stable and modestly above target. Performance is challenged by increased demand for CT services combined with hospitals reaching operational capacity. In order to reduce CT wait times, hospitals will have to increase CT hours. The NE LHIN's allocation for CT in 2011/12 is less than 2010/11 and will place pressure on wait times by the end of the fiscal year as hospitals meet their volumes targets.

IMPLEMENTATION PLAN

ALTERNATE LEVEL of CARE STRATEGIES and SOLUTIONS

TEMPLATE A: ALC STRATEGIES and SOLUTIONS

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Comparing LHIN regions, the per cent of hospital beds occupied by ALC patients is highest in Northeastern Ontario. The current ALC situation in the region is untenable and remains a priority for all leaders in our communities who are making a concerted effort to introduce new initiatives and improvements.

The complex nature of the problem is obvious - there is no single solution. Approaches need to be varied by individual communities to effectively address the situation and reverse the trend over time. As outlined in the NE LHIN ALC Action Plan, December 2007, a range of strategies and approaches have been identified to address the ALC challenge in Northeastern Ontario. The NE LHIN Action Plan addresses the ALC issue through six key strategies that focus on both resource/capacity issues and improvements in processes of care delivery.

Resource/Capacity Strategies:

The following strategies relate to the continuum of services required to provide an optimum range of services and supports for patients to allow for the appropriate care being delivered in the appropriate setting.

(1) Improved health programs for seniors at home.
(2) Prevention of senior hospital admissions in hospital emergency departments.
(3) Accelerated senior discharge after completion of hospital acute episode.
(4) Optimal configuration of community-based residential options and appropriate programs within those settings.

Improvements in Processes of Care Delivery:

(5) Improved hospital performance related to seniors.
(6) Improved health system performance and integrated care pathways.

We will continue to focus on a range of strategies that collectively work together to address the ALC challenge through additional service provision and also improving the processes used within our continuum of services.

At the provincial level the NE LHIN is working with its LHIN partners on the 8 LHIN High Priority Projects that were agreed to provincially as a result of the September 2010 Stocktake meeting: Excellent Care for All Act; Home First; Senior Friendly Hospitals Strategy; Provincial Falls Prevention Program; Rehabilitation and Complex Continuing Care Expert Panel; Reduction of ALC within 2 Days; Resource Matching and Referral; and Access to Care – Improving Accuracy of ED/ALC Data.

Current Status

As identified in the regular Stocktake Reports, the NE LHIN continues to have significant ALC challenges (typically around 30+% of acute care days in the NE are ALC).

Initiatives such as the Home First Strategy/Integrated Discharge Planning are being implemented in the four large HUB hospitals to start; assess/restore beds in Sudbury and Sault Ste. Marie; time-limited transitional care beds in Sudbury and Sault Ste. Marie; increased community services and seniors assisted living through both UPF; and Aging at Home years 1 and 2 appear to be having an impact on ALC.

The NE LHIN continues to work with hospital and community partners across the region to identify opportunities and strategies to decrease ALC. These tables have been formed in communities that are experiencing the most significant ALC pressures. They are the: Sudbury ALC Community Steering Group, Nipissing ALC Partnership, Parry Sound/NE LHIN ED/ALC Community Steering Committee, the Sault Ste. Marie/NE LHIN ALC Solutions Group, and the Cochrane Appropriate Level of Care/Senior's Working Group.

The NE LHIN will be reviewing the Senior Friendly Surveys to identify any further strategies that can enhance care for seniors while in the hospitals.

Goals

To demonstrate a sustained reduction in ALC in acute care over the next three years. This will be achieved by:

Resource/Capacity Strategies:

- Focus available year 3 Aging at Home on expanding seniors assisted living capacity.
- Develop a regional seniors' assisted living approach to leverage all opportunities to maximize resources within the region.
- Evaluate year 1, 2, and 3 Aging at Home programs with reallocations occurring as necessary.
- Address and monitor the Sudbury, Sault Ste. Marie and North Bay hospital bed situations as they unfold and are rectified over the next 6 months.
- Continue to work to expand the North East Specialized Geriatric Service (discussion is planned with NOSM re: opportunities for linkages and expansion).
- Implementation of additional transitional care beds in key Northeastern communities.

Improve Processes of Care Delivery:

- Implement the Home First Strategy and Integrated Discharge Planning in the four large HUB hospitals.
- Work with the NE CCAC around implementing the provincial direction of CCAC-led care pathways project.
- Develop a work plan to implement the CCAC's enhanced role.

Performance Monitoring:

- The NE LHIN will work with all hospitals in the region to develop a standardized approach and understanding re: accounting for ALC patients in acute care.
- The NE LHIN will participate in provincial ER/ALC monitoring activities (e.g. Stocktake Report).

The NE LHIN is committed to developing partnership with local municipalities, primary care providers, long-term care providers and others community partners in addressing ALC

challenges.

Consistency with Government Priorities

ALC related activity is consistent with the Government's ER/ALC Strategy which states, "Improving bed utilization expedites patient throughput and maximizes hospital capacity."

Reducing ALC will also have a positive impact on ER wait times in Northeastern Ontario.

Action Plans/Interventions	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Develop a regional seniors' assisted living approach to leverage all opportunities to maximize resources within the region	20%	20%	20%
Develop local solutions to the acute care bed consolidations at new single site hospital facilities in Sudbury, Sault Ste. Marie and North Bay	100%		
Expand the North East Specialized Geriatric Service	20%	20%	20%
Undertake a senior friendly assessment of all NE LHIN hospitals	100%		
Implement solutions for ALC long stay cases and hard to serve patients awaiting LTC placement in the four large HUB communities	33%	33%	33%
Complete ALC designation within 2 days of admission assessment and identify/implement programmatic solutions	50%	50%	
Develop a cohesive and comprehensive falls prevention program in the region (which is part of a broader provincial program)	50%	50%	
Implement LHIN-wide approach to weekly ALC reporting.	100%		

Expected Impacts of Key Action Items

While the addition of a number of new programs (Home First; Assess/Restore Beds etc) and enhancements to services (increased Assisted Living Services; etc.) will have a positive impact on the ALC rate, it is likely that the NE LHIN will not meet its MLPA target of 17% ALC days in acute care by April 1, 2011.

What are the risks/barriers to successful implementation?

- Resources available are insufficient to make the necessary impact e.g. insufficient resources to address supportive housing needs. Per *NE LHIN Seniors' Residential Housing Options – Capacity Assessment and Projections, March 16, 2009,* in order for the supply of seniors' housing to simply keep pace with projected growth in seniors' population, an increase of 8,409 beds or units over the next 25 years, or an average of 336 per year, would be required across the NE LHIN.
- HR recruitment and retention issues to address additional needs especially for Personal Support Workers.
- Additional out year funding beyond year 3 Aging at Home in 10/11 is unknown.
- The change management and time required for the process improvement initiatives are greater than anticipated.
- Factors that are outside the control of the AAH investments that impact on the level and intensity of health services required by seniors (I.e. rate of growth of senior's population in the NE, social determinants of health).
- Cross-ministry initiatives are required to support low-income seniors (Ministry of Municipal Affairs and Housing and Ministry of Health and Long-Term Care.

EMERGENCY DEPARTMENT WAIT TIMES

TEMPLATE A: EMERGENCY DEPARTMENT WAIT TIMES

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Reduce the number of non-urgent and less-urgent visits to Emergency Departments and continue to improve ED wait times performance and patient satisfaction in the NE LHIN.

Current Status

- There are 27 Emergency Departments across Northeastern Ontario. Nine hospital corporations representing 11 sites are part of the Emergency Room NACRS Initiative (ERNI) reporting system in Northeastern.
- As a whole, the NE LHIN ED wait times for high and low acuity patients (admitted and not) are at, or near, the provincial targets.
- The rate/1000 population of unscheduled ED visits in Northeastern Ontario continues to be nearly twice that of the province as a whole. This reflects the lack of primary care services (particularly after hours) and community support services in our communities that could

assist in avoidance of visits to the Emergency Departments.

- Based on 2009/10 data, the EDs in Northeastern Ontario had over 455,000 emergency visits of which 250,000 or 55% were non-urgent or less urgent visits.
- Key issues that impact the reduction of non-urgent and less urgent visits to the Emergency Department are: lack of primary care services; lack of community support services; shortage of human resources; and lack of residential housing to support these patients.
- LHIN interventions to date: CCAC case managers in Emergency Departments to assist with triage and moving patients out of EDs and back home or to appropriate placement; Geriatric Emergency Management nurses, Nurse Led Outreach Teams into long-term care homes; and enhanced community supports and access to services through NE CCAC and other HSPs through Aging at Home and Urgent Priorities resources.
- The four large HUB hospitals that received 10/11 Pay for Results funding implemented the following range of initiatives to reduce ED wait times: Patient Flow Coordinator; Clinical Nurse Specialist Flow Improvement/Medical Directive Implementation; Acute Care of the Elderly Service; Geriatric Diagnostic and Unscheduled Treatment Follow-up Service; Admission/Discharge Nurse; Short Stay Unit (SSU); Fast Track Zone; Early Discharge Program; Patient Flow Navigator Program; and Non-Urgent Patient Transportation Services.

Goals

1) To improve NE LHIN ED wait times performance across individual hospitals and the LHIN as a whole.

2) To reduce the rate of unscheduled ED visits, particularly for less-urgent and non-urgent visits.

The following actions/outcomes have been planned for over the next three years in our IHSP 2010-13 to meet the noted goals:

- Develop: e-referral and resource matching to expedite patient referrals out of acute care and divert ED visits; a wait time information system to provide detailed information about waits for post-acute care; and an ED reporting system to capture information on hospital ED length of stay to facilitate performance management.
- Ensure appropriate utilization of hospital beds and resources.
- Improve capacity management including surgical flow.
- Ensure that community services are available to enable patients, wherever possible, to avoid visiting the ED.
- Expand community-based projects to manage selected chronic diseases.
- Support comprehensive performance improvement training with respect to ED patient flow.
- Increase case management and system navigation.
- Support the NE LHIN's Emergency Department Network (that will address, among other things, a coordinated coverage plan for all 25 EDs in Northeastern Ontario).
- Improve triage and admission processes.
- Implement strategies to reduce ALC pressures.

Consistency with Government Priorities

ED related activity is consistent with the Government's ER/ALC Strategy which states:

1) Reducing the number of non-urgent cases that present at the ER will enable emergency clinicians to focus on patients with critical needs.

2) Improving triage and admission processes and reducing ambulance offload times will enable emergency clinicians to provide more efficient care.

Action Plans/Interventions	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
E-Referral – see eHealth section for details			
Ensure appropriate utilization of hospital beds and resources	20%	20%	20%
Improve capacity management including surgical flow – see section on surgical services optimization for details			
Ensure that community services are available to enable patients, wherever possible, to avoid visiting the ED	20%	20%	20%
Expand community-based projects to manage selected chronic diseases – see section on diabetes for details			
Support comprehensive performance improvement training with respect to ED patient flow	33%	33%	33%
Increase case management and system navigation	33%	33%	33%
Support the North East LHIN's Emergency Department Network (that will address, among other things, a coordinated coverage plan for all 25 EDs in the NE)	33%	33%	33%
Improve triage and admission processes.	33%	33%	33%
Implement strategies to reduce ALC pressures – see ALC section for details			

Expected Impacts of Key Action Items

- Reduced rate of unscheduled ED visits (particularly for less-urgent and non-urgent cases).
- Reduce ED wait times (all indicators).
- Improved patient flow within the hospital and community sectors.
- Improved management of diabetes.

What are the risks/barriers to successful implementation?

As much as the implementation of various strategies to help relieve ER and ALC pressures and improve wait times is through Aging at Home and Urgent Priority funding, there is an increasing demand for these services that exceeds funding available. The lack of human resources, space

and adequate funding is preventing this goal from being achieved.

- Many small hospitals rely on physician locums to maintain full coverage of their EDs. This strategy, although necessary, places the on-going ED coverage at risk.
- At the community level many of the interventions rely on partnerships with primary care providers who are, for the most part, outside of the LHIN mandate.

AGING at HOME

TEMPLATE A: AGING at HOME

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

The main focus for Years 1 and 2 of the AAH was to create a continuum of community-based services for seniors and their caregivers to enable seniors to live independently and safety in their own homes for as long as possible.

The main focus for Year 3 was to enhance community services for seniors and address ED wait times and ALC pressures. The NE LHIN continues to have the highest rate of ALC in acute care settings in the province. In-line with the provincial direction of addressing ED wait times and ALC pressures, the NE LHIN will focus on the low income frail elderly within each of the following four priorities:

- Develop seniors' assisted living capacity;
- Implement the North East Home First Strategy starting in the four large HUB hospitals and subsequently rolling-out to the remaining 20 general hospitals in the region;
- Expand the North East Specialized Geriatric Services; and
- Establish interim and permanent long-term care beds and assess/restore beds.

Going forward into 2011/12, the NE LHIN will continue to work on ensuring that investments from all three years of the AAH Strategy are contributing to relieving ED/ALC challenges in the region.

Current Status

The NE LHIN continues to work with hospital and community partners across the region to identify opportunities and strategies to decrease ALC. Community tables have been formed in communities that are experiencing the most significant ALC pressures. They are the Sudbury ALC Community Steering Group, Nipissing ALC Partnership, Parry Sound/NE LHIN ED/ALC Community Steering Committee, the Sault Ste. Marie/NE LHIN ALC Solutions Group, and the Cochrane Appropriate Level of Care/Senior's Working Group.

Goals

To enhance community services for seniors and address ED wait times and ALC pressures by investing in the following four priorities:

(1) Seniors' Assisted Living

- Focus available year 3 AAH funding on expanding seniors' assisted living capacity.
- Develop a regional senior assisted living approach to leverage all opportunities to maximize resources within the region. One year secondment position at LHIN to implement the new Assisted Living Policy began in January 2011.

(2) North East Home First Strategy

- Improve patient flow through the system by:
  - Ensuring that frail elderly seniors are discharged upon completion of their acute care with appropriate home supports; and
  - Avoiding unnecessary hospital admissions by ensuring appropriate home support services.

(3) North East Specialized Geriatric Services

- Assist seniors with complex multiple needs to stay at home longer.
- Continue to work to expand the North East Specialized Geriatric Service (further discussion is planned with the four HUB hospitals re: opportunities for linkages and expansion).

(4) Interim and Permanent Long-Term Care Beds and Assess/Restore Beds

- Increase number of long-term care beds for frail seniors with high MAPLE scores.
- Develop the continuum of care options in the region

The Aging at Home strategy will be evaluated to identify whether:

- It is reaching the target population of seniors 65+.
- It is meeting the identified goals and objectives.
- It is supporting health system integration from the perspective of seniors, caregivers, health service providers and the LHIN.
- It is delivering on models that are sustainable.
- It is aligned with MOHLTC and LHIN objectives around ED/ALC performance.

The NE LHIN will be using its Year 3 Aging at Home funding to support the implementation of these projects. In order for the NE LHIN to increase assisted living capacity to the levels identified in our Seniors' Housing Study, additional funding above the year three allocations will be required. The NE LHIN is continuing to work with municipalities to look for opportunities to partner in developing more seniors' assisted living units and services.

Consistency with Government Priorities

The AAH Strategy as implemented by the NE LHIN meets the objectives of the provincial government for this initiative.

Action Plans/Interventions	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Expand seniors assisted living across the region	20%	20%	20%
Expand the North East Specialized Geriatric Service	20%	20%	20%
Implementation of the Home First	60%	40%	

Strategy			
Construction of the long-term care beds in Timmins and Wawa	40%	50%	10%
Establish interim and permanent long-term care beds and assess/restore beds in large four urban centres	50%	50%	
Implementation of the NE LHIN evaluation framework	100%		

Expected Impacts of Key Action Items

As a result of implementing the AAH Strategy, the following impacts are expected:

- Reduction in ALC
- Expansion of community services for the frail elderly
- Improved patient flow within the hospital and community sectors
- Reduction in ED wait times

What are the risks/barriers to successful implementation?

- Resources available are insufficient to make the necessary impact e.g. insufficient resources to address supportive housing needs. Per *NE LHIN Seniors' Residential Housing Options – Capacity Assessment and Projections, March 16, 2009:* In order for the supply of seniors' housing to simply keep pace with projected growth in seniors' population, an increase of 8,409 beds or units over the next 25 years, or an average of 336 per year, would be required across the NE LHIN.
- Human resource recruitment and retention issues to address additional needs especially for Personal Support Workers.
- Additional out year funding beyond year 3 Aging at Home in 10/11 is unknown.
- The change management and time required for the process improvement initiatives are greater than anticipated.
- Factors that are outside the control of the AAH investments that impact on the level and intensity of health services required by seniors (I.e. rate of growth of senior's population in Northeastern Ontario, social determinants of health).
- Cross-ministry initiatives are required to support low-income seniors (Ministry of Municipal Affairs and Housing and Ministry of Health and Long-Term Care).

ABORIGINAL/FIRST NATION/MÉTIS HEALTH SERVICE

ABORIGINAL/FIRST NATIONS/MÉTIS : HEALTH SERVICES

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Aboriginal/First Nations/Métis Health Services – An Integrated Approach

Effective engagement with Aboriginal/First Nations/Métis stakeholders is a high priority of the NE LHIN. The NE LHIN has worked to advance and improve the health status of this population group

throughout Northeastern Ontario, which conservatively represents 10% of the overall population of the region. The health needs of Aboriginal communities across the region are significant in scope and magnitude. Aboriginal/First Nations/Métis health/health services is a priority on its own, however, it must be, and is, included as an integrated approach to each IHSP priority.

Current Status

Engagement that is respectful of language, nationhood, culture and spiritual beliefs within Aboriginal/First Nations/Métis communities and health service providers continues to be a priority across the region. The NE LHIN has focused on capacity building and sustainability of current Aboriginal health service providers to increase the health status of this population group.

The Local Aboriginal Health Committee (LAHC) continues to advise the NE LHIN on health service priorities within Aboriginal (First Nation, Métis, urban, rural) communities and opportunities for the integration and coordination of health care services. The LAHC and NE LHIN work collaboratively on targeted engagement activities.

Specific research projects, such as the Mental Health and Addictions Framework (completed in 2010) and the Health Status and Environmental Scan for Aboriginal/First Nations/Métis people in Northeastern Ontario (completed in March, 2011) are examples of successful outcomes of the LAHC. The NE LHIN received funding from the Aboriginal Health Transition Fund (AHTF) for these latter two projects as well as Weeneebayko Area Health Authority (WAHA) integration plans and support. All AHTF projects have completed an evaluation report which was showcased at a provincial Aboriginal Health Transition Fund (HTF) Knowledge Forum in March 2011.

The following Aboriginal/First Nations/Métis representation is included within the NE LHIN organizational structure: one Board member from Hudson and James Bay Coast; one Senior Director responsible for Aboriginal Services; one Senior Aboriginal Advisor and one Aboriginal Consultant.

Furthermore, the NE LHIN's Health Professional Advisory Committee (HPAC) has two Aboriginal members. These new members represent different health professions, health sectors and geographical areas in the NE LHIN and they provide advice and guidance to support the NE LHIN's priorities.

The total Aboriginal population in Northeastern Ontario's geographic region from urban, semi-urban, rural to isolated remote communities is estimated conservatively at over 55,000 people located within 42 First Nations and 14 urban and rural communities. The Aboriginal diversity within the NE LHIN by nationhood is Cree, Ojibwa (Anishnabe), Odawa, Algonquin and Métis ancestry. .

The NE LHIN funds 36 Aboriginal health service providers at a total of $28.5 million, including one hospital, one long-term care home, 30 community support service agencies, seven mental health and addiction agencies, and one community health centre. These 36 health service providers are dispersed throughout the NE LHIN region and are found in urban centres, rural communities, remote and isolated areas, across 38 First Nations.

TEMPLATE A: PART 2: GOALS and ACTION PLANS

Goal(s)

To improve the health status and access to health services delivered to Aboriginal/First Nations/Métis population in the NE LHIN, with a particular focus on mental health and addictions.

To advance a continuum of holistic health services determined by Aboriginal/First Nations/Métis populations.

To promote and support culturally appropriate programming and services that ensures accessibility

and inclusion.

To collaborate, develop and implement strategies that strengthen and integrate local health services to Aboriginal/First Nation/Métis populations.

To support the advancement, alignment and integration of services for Aboriginal health service providers and Aboriginal/First Nation/Métis communities.

To promote culturally appropriate services within all NE LHIN health service providers.

To ensure an understanding and compliance with reporting requirements as outlined in the M-SAA, H-SAA and L-SAA.

To monitor the WAHA integration to ensure services are enhanced for persons residing on the James and Hudson Bay Coast.

Consistency with Government Priorities

The identified goals are aligned with the requirements of the Local Health System Integration Act and are outlined by the NE LHIN as a priority.

Other key government initiatives such as the provincial Ontario Aboriginal Health Policy and the Aboriginal Healing and Wellness Strategy are included in the planning and alignment of health services with consideration given to the following goals of the Aboriginal Health Policy:

- To improve the health of Aboriginal individuals, families, communities and nations through equitable access to health care;
- To provide Aboriginal specific health care facilities;
- To provide standards of care;
- To provide culturally appropriate health services; and
- To provide a healthy environment.

The NE LHIN Integration Strategy (2008) identifies principles that will guide integration activities within the Aboriginal/First Nation/Métis communities. The principles recognize:

- The Ontario Aboriginal Health Policy and Aboriginal peoples' rights to determination in health;
- existing integration processes underway within First Nation, Métis and urban Aboriginal communities and health structures which improve the health status of those populations; and
- Choices for First Nation, Métis and urban Aboriginal communities including culturally appropriate and traditional health services.

Action Plans/Interventions	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Improve access to primary care for Aboriginal/First Nations/Métis people by recognizing barriers and limitations	20%	20%	20%
Improve access to integrated diabetes care through support of the current Ontario Diabetes Strategy	30%	30%	30%

Recognize culturally appropriate care and traditional healing services within existing health system and identify how these services will improve health determinants such as chronic disease management, treatment, prevention and education to Aboriginal/First Nations/Métis people throughout Northeastern Ontario	20%	20%	20%
Develop collaborative strategies that aim to strengthen and integrate local health services within the Aboriginal/First Nations/Métis populations	25%	25%	25%
Monitor on-going planning and funding of the Weeneebayko Area Health Authority integration for the James/Hudson Bay Coast	20%	20%	20%
Ensure compliance of all Aboriginal HSPs with reporting requirements and indicators in the M-SAA, H-SAA and L-SAA Agreements and provide the necessary support and training as required	33%	33%	33%
Share information from the Health Status and Environmental Scan within the NE LHIN Region Utilize data, research and health information generated by environmental scan to monitor the overall improvement in the health status of the Aboriginal First Nation and Métis population	30%	30%	30%
Develop an Aboriginal First Nation and Métis Mental Health and Addictions Strategy for the NE LHIN that supports the recommendations of the Northeastern Ontario Mental Health and Addictions Framework research document (March 2011)	30%	30%	30%

Measures of Success

The NE LHIN Aboriginal/First Nations/Métis communities are engaged throughout the region. The engagement activities lead to an overall improvement and enhancement of the Aboriginal people's health status, eliminate the disparities between the communities and are inclusive of alternative health and healing practices.

What are the risks/barriers to successful implementation?

The vast geography of Northeastern Ontario poses a challenge to planning and engagement

strategies within the Aboriginal communities. The remoteness of certain communities can be a barrier to developing integration strategies among Aboriginal health service providers.

The NE LHIN respects Aboriginal/First Nations/Métis rights to determination in health and utilizes the Ontario Aboriginal Health Policy where applicable. The Indian Health Policy (IHP) adopted by the federal government recognizes the legal and traditional relationship the federal government has with Aboriginal peoples which stems from the constitution, Treaties and customary practices.

The NE LHIN recognizes the disadvantaged circumstances under which many Aboriginal communities exist compared to mainstream Northern Ontario, especially in terms of health status and care. The magnitude of this problem is more significant in the NE LHIN region The high number of health disparities, poverty, low to poor socioeconomic conditions, and high unemployment are factors that hinder the advancement of Aboriginal peoples' cultural, social, emotional well being and overall health status.

FRENCH LANGUAGE HEALTH SERVICES

TEMPLATE A: FRENCH LANGUAGE HEALTH SERVICES

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Effective engagement with Francophone stakeholders is a high priority of the NE LHIN, given that Francophones represent 24% of the North East's population. Community consultations for the purpose of validating the priorities in the IHSP indicated that an integrated approach to addressing challenges for the Francophone community is required. Effective engagement with Francophone stakeholders will continue both internally with the French Language Services team of the NE LHIN and externally with the recent announcement and signed agreement with the new French Language Health Planning Entity. The NE LHIN integrates FLHS within each priority and within its mission and vision.

Current Status

The NE LHIN is making significant progress in its priority of improving the integration of French Language Services (FLS) within the local health care system.

The NE LHIN now has a signed agreement with the Réseau du mieux-être francophone du Nord de l'Ontario as the French Language Health Planning Entity (FLHPE) for the North East and the North West LHINs. The NE LHIN is the Lead LHIN for the FLHPE. Discussions have started towards the development of a joint LHIN/Entity action plan for 2011-2012.

The NE LHIN FLS Unit consists of three FLS Coordinators and a Senior Director responsible for the French Language Services priority. This new FLS Unit continues to implement French language services both within the NE LHIN as a Crown Agency and in the local health care system. The team also supports health service providers with the preparation of FLS designation plans.

Revised internal processes for the implementation of FLS, an updated FLS section on the NE LHIN web site and continued support and education for health service providers on FLS matters are some of the communication strategies that help the NE LHIN increase knowledge and awareness of FLS.

The NE LHIN currently has 36 health service providers (HSPs) officially designated under the *French Language Services Act*, and has identified 69 other HSPs to work towards the implementation of FLS.

In order to help ensure and monitor continuous improvement in the quality, accessibility and integration of FLS, the FLS accountability process was refined. Currently, 115 HSPs have a FLS performance indicator in their 2011-2014 multi-sectoral service accountability agreement, their 2010-2013 long-term care service accountability agreement or their 2011-2012 hospital service accountability agreement.

The NE LHIN French Language Services staff continues to work with the five bilingual and Francophone Community Health Centres (CHCs) to implement a joint action plan. This plan will lead to increased access to the primary health care sector for Francophones, joint integration initiatives between the CHCs, increased awareness of the programs and services delivered by CHCs to the Francophone community and identification of opportunities for service enhancement by identifying common priorities in the primary care sector.

- The FLS Unit is actively involved in all NE LHIN activities, such as integration, community engagement, decision support and communications to ensure a consistent integrated approach is used in the implementation of FLS.

Goals

The NE LHIN, with the help of FLHS providers, has identified the following three main objectives to guide French language planning activities:

- Continuous improvement in the quality, accessibility and integration of FLHS in all LHIN internal and external activities
- Community empowerment and continued community engagement with the Francophone community with the support, assistance and guidance of the new FLHPE in order to impact the overall health system and improve health status
- Accountability of health service providers to their community with the inclusion of the FLS indicator

Consistency with Government Priorities

These goals are in keeping with the *French Language Services Act* and the FLS requirements under the *Local Health System Integration Act*.

The NE LHIN's work is also aligned with the Ministry's results based planning key result areas for French language services:

1) To expand FLS Capacity;
2) To increase knowledge and awareness of FLS;
3) To engage the Francophone Community; and
4) To integrate/coordinate FLS within the local health system.

Action Plans/Interventions	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
FLS Capacity			
• Target 10% per year of the HSPs	25%	25%	25%

that are identified to implement FLS and work towards the development of a FLS designation plan			
• Inclusion of a FLS indicator in 22 hospital service accountability agreements (H-SAA)	100%	N/A	N/A
• Inclusion of a FLS indicator in 20 long-term care service accountability agreements (L-SAA)	25%	75%	N/A
• Inclusion of a FLS indicator in 73 multi-sectoral service accountability agreements (M-SAA)	75%	25%	N/A
• Monitoring of FLS indicator in 115 service accountability agreements (73 M-SAA, 22 H-SAA, 20 L-SAA)	100%	100%	100%
Knowledge and Awareness			
• Provide education and monitor implementation of internal FLS processes	50%	25%	25%
• Implement external FLS knowledge & awareness strategies, such as FLS page on Web site, FLS education sessions for HSP	100%	100%	100%
• Develop and monitor quality assurance processes and protocols for bilingual written correspondence	75%	25%	N/A
Francophone Community Engagement – French Language Health Planning Entity (FLHPE)			
• Develop a joint annual work plan with the FLHPE	100%	100%	100%
• Establish a NE-NW LHIN Liaison Committee with the FLHPE.	100%	N/A	N/A
• As Lead LHIN, initiate and coordinate a minimum of 2 meetings of the NE-NW LHIN Liaison	100%	100%	100%

Committee			
Francophone Community Engagement – LHIN as a Crown Agency			
• Develop and implement an action plan with 5 francophone/bilingual Community Health Centres (CHC) to support the NE LHIN's priorities	50%	25%	25%
FLS Integration			
• Develop a FLS guide to complement and support the NE integration strategy and process	100%	N/A	N/A
• Work with the new North Bay Regional Health Centre (NBRHC) to develop FLS policies and procedures that will support the implementation of FLS in the new hospital and lead to the development of a FLS Designation plan	50%	50%	N/A
• Work with the proposed Anchor Agency for Mental Health and Addictions in Algoma to ensure that FLS issues are included in the planning process	50%	50%	N/A
• Work with the CHCs in developing an OTN initiative for shared physician services that will lead to enhanced access to primary care for the Francophone community	75%	25%	N/A

Measures of Success

FLS Capacity:

7 additional HSPs have initiated the development of a designation plan

All 115 identified or designated HSPs have a FLS indicator in their accountability agreement

50% of HSPs have shown an improvement in their FLS indicator at the end of the first year of their agreement, and 75% have reached their FLS indicator target by the end of their agreement

Knowledge and Awareness:

100% of NE LHIN staff have received education regarding the FLS Internal Processes

100% of NE LHIN staff are aware of the NE LHIN's FLS obligations as a Crown Agency

Knowledge and awareness opportunities are offered to 100% of identified and designated HSPs

Quality assurance processes and protocols are implemented for all bilingual written correspondence

Francophone Community Engagement:

Joint action plan is developed and approved between the NE LHIN and the FLHPE by September 30, 2011

A joint work plan is developed annually between the NE LHIN and the FLHPE

A NE-NW LHIN Liaison Committee with the FLHPE is established and meet a minimum of twice a year

A joint action plan is developed with 5 francophone/bilingual CHCs and specific initiatives have been completed

FLS Integration

FLS Guide is included in the integration strategy and process

The NBRHC completes a designation plan by the end of 2012 and submits a request for designation to the NE LHIN by the end of 2013

Planning for FLS is included in the work plan of the Anchor Agency for Mental Health and Addictions in Algoma

The CHCs successfully launch an OTN joint initiative to share physician services

What are the risks/barriers to successful implementation?

FLS Capacity:

HSPs may be involved in other initiatives which could delay the development of a designation plan

HSPs may not achieve expected FLS indicator targets due to challenges with service coordination, recruitment and retention of French-speaking staff

Knowledge and Awareness:

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

Francophone Community Engagement:

Recruitment of staff at the new FLHPE may be delayed due to limited qualified Francophone human resources in Northern Ontario

Initiatives identified in the joint action plan with the CHCs are still in the exploratory stages and may not be implemented until consensus is reached

FLS Integration

The NBRHC is unable to complete the deliverables in the FLS work plan by the expected timelines

The CHCs are unable to recruit a physician for their OTN initiative

ADDICTION AND MENTAL HEALTH SERVICES

TEMPLATE A: Addiction & Mental Health Services System Integration

The existence of separate treatment programs for addiction and mental health, separate funding envelopes, and differing treatment approaches are significant barriers to the effective support for persons with addiction and/or mental health problems (as many as 50% of people suffering from mental illness also face an addiction). An integrated addiction and mental health system in Northeastern Ontario will help to address the needs of individuals and communities across the region. An integrated system also has the potential to create better links with other key areas such as housing, income, employment, and social supports that are all important components to providing a comprehensive approach to mental health and addiction treatment and support.

In Algoma, the NE LHIN is working with partners to establish an integrated addiction and mental health Anchor Agency.

Current Status

There is a full continuum of addiction and mental health treatment services currently being provided throughout the NE LHIN region

The NE LHIN has 83 funded programs across the region which provide the continuum of addiction and mental health services including gambling treatment. In Algoma there are 13 agencies providing 129 services in various parts of the district.

The key needs of this group (apart from clinical intervention) are improved access to services, less fragmented system of services, better awareness of services available, and improved access to services after hours and a more recovery/consumer focused service system.

In 2011/12 a plan to decentralized 12 tertiary children's mental health beds will be completed.

The NE LHIN has provided funding to the Sudbury CMHA to develop a plan that will identify opportunities for a shared back office service for mental health service providers.

Goals

During 2011/2012 the NE LHIN will be working with an Algoma project team to integrate the services of 13 organizations into a single mental health and addiction Anchor Agency. The goal is to integrate services to improve access to care for consumers and their families. The NE LHIN has hired a project coordinator to oversee this important project.

The NE LHIN is working with key stakeholders and CCIM to implement version 2 of OCAN. The use of OCAN version 2 has been included in the provider's MSAA agreements with the NE LHIN.

The NE LHIN will work with the MOHLTC to implement/expand the Rebound pilot program into an existing Rebound focused program in Sault Ste. Marie.

Through NE LHIN funding, training of the GAIN SS for mental health and addiction service providers in the region has been completed and an evaluation of the training process has taken place. The NE LHIN is now working with the Centre for Addiction and Mental Health and the Champlain LHIN to provide and e-version of the GAIN SS for providers.

The NE LHIN continues to collect intelligence and to work with providers to implement plans to reduce the readmission rates of mental health clients in the hospital emergency rooms.

We continue to work with North Bay Regional Health Centre, MCSS/MCYS and our children's mental health partners to decentralize the regional children's tertiary mental health beds.

Consistency with Government Priorities

- Improves access for consumers.
- Provides a viable alternative (rather than the ED) to consumers who need assistance.
- Provides for a more consumer and family directed service as per the MOHLTC Ten Year strategy and the Select Committee Report.
- Re-directs efficiencies back into the system in order to address gaps in services.
- Builds a strong critical mass of services that will help to recruit and retain skilled professionals.
- Provides after hour options for consumers and their families thereby decreasing frequent visits to the ED.

Action Plans/Interventions	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
We will deliver integrated addiction and mental health services in Algoma	20	40	40
Implement the plan to decentralize the 12 Children's Tertiary mental health beds	70	30	
We will implement the rebound drug awareness pilot program in the NE LHIN Region	100		
We will implement the CCIM – HR & MID systems to the integrated Anchor Agency in Algoma	25	75	
We will work with HSPs to implement measures to reduce hospital revisits	100		

Measures of Success

- Decreased number of revisits to ED in Algoma
- Decreased number of accountability agreements in Algoma
- Increase in number of consumers accessing Algoma services (other than hospital)
- Improved consumer experience with services
- Treatment gaps identified and resources re-directed where necessary
- Increased volumes in some functional centres

What are the risks/barriers to successful implementation?

- Integration process can be slow and difficult
- Efficiencies may be minimal
- Initial costs to establish Anchor Agency may be high
- There may be resistance from some providers

DIABETES CARE

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Chronic Disease Prevention Management – Diabetes Care

To address the high burden of chronic disease through diabetes in the NE LHIN and improve/optimize the health and wellness of all residents in the region.

The NE LHIN is committed to improving access to diabetes care by supporting the roll-out of the provincial Diabetes Strategy.

The three MOHLTC Ontario Diabetes Strategy key performance measures are:

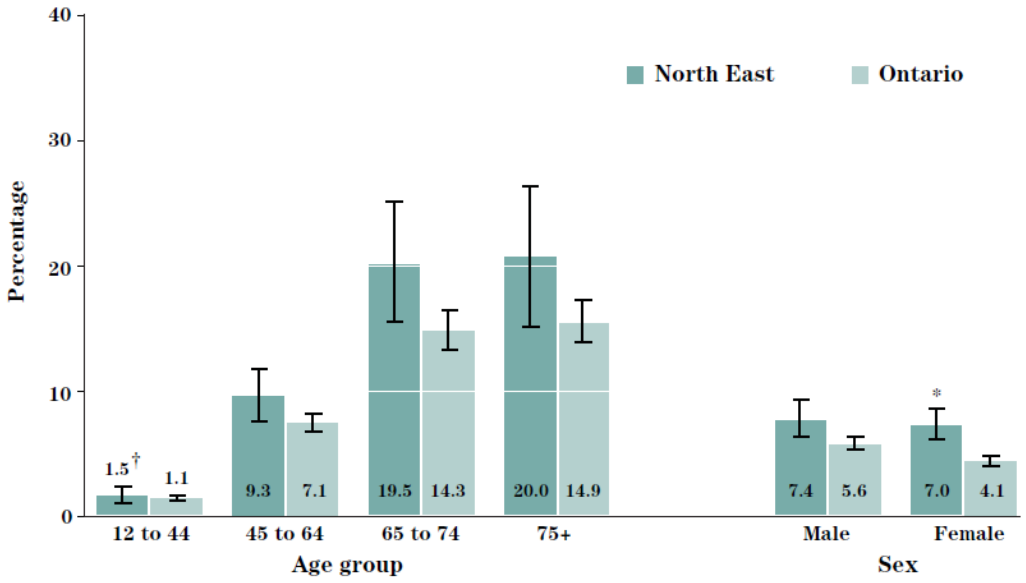
a) Reduce risk
b) Increase access to coordinated diabetes care
c) Improve management of diabetes according to Clinical Practice Guidelines

Current Status

According to the Health System Intelligence Project report released in October 2007, the prevalence of diabetes is significantly higher in the NE LHIN than in the rest of the province. The report indicated that compared to provincial rates, the NE LHIN has significantly higher rates associated with diabetes for:

- Inpatient hospital discharge
- Mortality
- Emergency Department visits

Figure 1: Prevalence of diabetes by age group and sex, population aged 12+, North East LHIN and Ontario, 2005.



Source: 2005 Canadian Community Health Survey, Statistics Canada, Ontario Share File.
† Coefficient of variation 16.6% to 33.3% - interpret with caution.
* Significantly different from provincial average based on assessment of 95% confidence intervals.

Diabetes Management Programs

In the NE LHIN, diabetes services are provided through several models of care. The following list encompasses the majority of programs/services delivered in the NE LHIN region through a variety of models:

- 29 Adult Diabetes Education Programs
- 4 Youth/Paediatric Programs
- 27 Family Health Teams
- 6 Community Health Centres
- 3 Aboriginal Health Access Centres
- 16 Nursing Stations
- 7 Nurse Practitioner Led Clinics
- Sault Ste. Marie Group Health Centre
- Primary Care Physicians
- Pharmacists

Given the vast geography of Northeastern Ontario and its unique demographics, service delivery for diabetes management varies significantly across the LHIN. For example, the more highly populated communities have access to interdisciplinary teams that combine both primary care and diabetes education programs, while rural and remote communities are serviced through outreach or via Nursing Stations and Nurse Practitioner Led Clinics.

Diabetes Clinical Indicator Data for NE LHIN

As identified in the eHealth Ontario Diabetes Care Report (November 2010), there are more than 1,004,662 Ontarians living with diabetes. Table 1 provides a comparison of diabetes indicators for the NE LHIN and Ontario.

Table 1: Diabetes Clinical Indicators Compared for NE LHIN and Ontario, 2010.

	Individuals living with diabetes	A1C test in a last 6 months	LDL test in last year	Retinal Exam in last 2 years	All 3 indicators within guidelines
Ontario	1,004,662	55.9%	68.2%	66.1%	37.8%
NE LHIN	55,793	46.4%	52.9%	70.6%	31.8%

Provincial/LHIN Diabetes Care Report, November 2010

Goals

To ensure increased access to integrated diabetes care, the NE LHIN supports the implementation of the Ontario Diabetes Strategy across its region.

The NE LHIN has identified two goals:

- Environmental Scan of the health service providers who deliver diabetes care
- Support the implementation of the Self-Management Initiative

Consistency with Government Priorities

The Ontario Diabetes three-year Strategy targets prevention, self-management, increased access to care, and the treatment of diabetes. The NE LHIN will work with health service providers who deliver diabetes care; support the implementation of Self-Management Initiatives; and assist the Ontario Diabetes Strategy in meeting its targets by collaborating with the Regional Coordinating Centre to identify and determine the needs of the local population.

The Ontario Diabetes Strategies provincial goals are:

- To ensure all people with diabetes have access to a primary health care provider
- To ensure that 80 per cent of people with diabetes aged 18 and older have received the three tests/exams listed below within the indicated guideline period:
    i. HbA1c test in the past 6 months (measure of blood sugar control)
    ii. LDL-Cholesterol test in the past year
    iii. A Retinal Eye Exam in the past 2 years

NE LHIN Action Plan:

Action Plans/Interventions	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
On-going primary care engagement with the aboriginal communities as it relates to diabetes and chronic disease	25%	25%	25%
Support the roll-out of the Ontario Diabetes Strategy	50%	50%	N/A
Collaborate with the new Diabetes Regional Coordinating Centre	50%	50%	N/A
Support the implementation of the Diabetes Registry across the Northeast region	50%	50%	N/A
Share NE LHIN expertise and information on HSPs and NE LHIN chronic disease related data with the Regional Lead responsible for the implementation of the Self-Management Initiative	50%	50%	N/A
Partner with CHCs, and HSPs who deliver diabetes care to support a Chronic Disease Prevention Management (CDPM) forum in the NE LHIN	100%	N/A	N/A
Hold a Chronic Disease Prevention Management Forum in the NE LHIN	100%	N/A	N/A
Evaluate the added value of the CDPM forum with health service providers	N/A	100%	N/A
Identify priorities for service enhancement in partnership with health service providers, and those that provide diabetes care in CDPM	N/A	50%	50%

Measures of Success

In the fall of 2010, the MOHLTC released its Provincial/LHIN Diabetes Care report. The report identified gaps between evidence based guidelines and the care that Ontarians with diabetes received. Two NE LHIN specific goals were identified to work toward closing the gaps in the current system and help the Ontario Diabetes Strategy meet its expected short-term, intermediate and long-term outcomes.

Goal 1: Environmental Scan

- Compile information pertaining to the delivery of diabetes care. Share the information with the Diabetes Regional Coordinating Centre in an effort to plan future diabetes initiatives that link to the overall Ontario Diabetes Strategy

Goal 2: Self-Management (SM)

- Work closely with the Regional Lead for Diabetes Self-Management for the North East region to ensure the SM programs are aligned with NE LHIN priorities for diabetes care

What are the risks/barriers to successful implementation?

Risks for Goal 1: Environmental Scan

- Local planning of diabetes initiatives are not aligned with the NE LHIN overall priority

Risks for Goal 2: Self-Management

- As the implementation of diabetes strategy will be completed by 2012, the on-going management of the programs and initiatives may be jeopardized due to the availability of the on-going financial resources

HEALTH HUMAN RESOURCES

TEMPLATE A: HEALTH HUMAN RESOURCES

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Health human resources (HHR) and timely access to the necessary health professionals in Northeastern Ontario is perhaps the challenge most frequently identified by all individuals working in health care.

Each of the IHSP priorities has a human resources dimension. The challenges facing our health care system and the providers within it are well documented. The NE LHIN will work with the province, local health service providers, communities and individuals to determine innovative ways to utilize our current workforce and to attract additional professionals to the region and retain them.

Current Status

The North East Health Human Resources Steering Committee was established in early 2009.

The Committee provides system-wide leadership in the development of the Northeastern Ontario Health Human Resources Plan which gives consideration to local, cultural and language-related HHR issues.

A comprehensive range of HHR planning and coordination activities is required to support the delivery of health services within the NE LHIN, including:

- An inventory of HHR in Northeastern Ontario;
- A list of current vacancies with recent historical experience;
- Projections of future HHR needs; and
- Strategies for recruiting and retaining needed HHR.

Goals

To collaborate with all stakeholders to create a system-wide framework to anticipate HHR requirements and mitigate the service delivery challenges as they pertain to the NE LHIN health care workforce. The NE LHIN is committed to working with municipalities, medical schools, academic research units, other ministries, colleges and universities.

Consistency with Government Priorities

Ontario's vision for health care embraces a goal that there will be the right number and mix of health care professionals, when and where they are needed.

When compared to Ontario and the rest of Canada, Northeastern Ontario has significant shortages

in a number of health human resources areas including: physician specialists, physiotherapists, and occupational therapists. However, there are instances where the number of professionals in Northeastern Ontario compares favourably to Ontario and Canada on a per capita basis; nonetheless there is a significant misdistribution in the region with many communities experiencing ongoing shortages. Chronic vacancies which already exist are made worse by both the aging of the health service workforce and general population as a whole. This leads to an increasing demand for services.

Information about the number of people working in health care is generally hard to come by and there is no one place to go to identify current vacancies on a regional basis. There are, however, some good building blocks in place that will help to address long-standing HHR issues.

A broad definition of the scope of HHR is being used at this stage of the NE LHIN's planning efforts, including recruitment and retention, partnerships and collaboration, training and development, and occupational health and safety. Planning is inclusive of all HHR including leadership, physicians and other professionals, staff, students and volunteers.

Action Plans/Interventions	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Develop a NE HHR Directional Plan	100%		
Create an inventory of NE HHR workforce	100%		
Maintain support role in the implementation of the Action Plan for Enhancing Personal Support Occupations in the North East	25%	50%	25%
Research and apply an HHR workforce forecasting methodology	75%	25%	
Develop and implement a shared recruitment service	25%	50%	25%
Establish formal linkages to Aboriginal and FLHS planning structures	75%	25%	
Research and develop a shared HHR intranet system (portal)		25%	50%
Research the functional requirements and develop a plan for a system level HRIS	50%	50%	
Develop a plan that leverages HFO resources and mobilizes HFO-MRA's efforts in recruitment and retention	25%	75%	

Expected Impacts of Key Action Items

- The first cohesive and collaborative planning approach to mitigate HHR pressures for Northeastern Ontario.
- Increased access to recruitment and training opportunities for various occupations including Personal Support.
- The introduction of HHR forecasting approach that is conducive to Northeastern Ontario's health system's uniqueness.
- Sound data and information on our health care workforce and on the HR practices (and effectiveness) used by our health service providers.

What are the risks/barriers to successful implementation?

- Availability of resources
- Securing the buy-in from the various stakeholders (local and provincial)

OPTIMIZE SURGICAL SERVICES

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

The NE LHIN undertook a review of surgical services currently being delivered in hospitals throughout the region to ensure that access and quality care is maintained in the future. The mandate of the project was to review the surgical volumes, diagnostics and resource requirements to meet Northeastern Ontario's surgical needs. A surgical Optimization Steering Committee was established to steer the project.

Current Status

The Surgical Optimization Steering Committee is moving forward with the three-year action plan to carry out the 33 recommendations stemming from the *Surgical Optimization Study Report, May 22, 2009.*

The following four priorities have been addressed by the Surgical Optimization Steering Committee:

- Thoracic Surgical oncology;
- Vascular surgery;
- Orthopaedic as it relates to Hip and Knee Replacement; and
- Call schedule for urgent/emergent surgical care.

Thoracic Surgical Oncology

Objectives :

- HRSRH and SAH to meet quality standards of Cancer Care Ontario (CCO).
- HRSRH to develop a distributed diagnostic model.

Update:

- HRSRH has moved forward with compliance with the CCO standards for Thoracic Surgical Oncology and has received their level 1 designation.
- HRSRH has implemented thoracic cancer multidisciplinary case conferences (MCCs) that occur

monthly and are available for participation at SAH by videoconference. The opportunity to increase the frequency of the MCCs will be explored once the third thoracic surgeon is available to participate.

- SAH are not able to meet CCO standards and will need to decide how to address the thoracic surgical oncology procedures being done at their facility.

Vascular Surgery

Objective:

- Address request from SAH to enhance their vascular program within the context of creating a singular vascular program in Northeastern Ontario.

Update:

- The vascular surgeons from Sault Area Hospital and Hôpital regional de Sudbury regional Hospital met on February 8, 2011 to discuss the EVAR request from Sault Area Hospital.
- The vascular surgeons have agreed to maintain status quo in the distribution of the vascular surgery in the NE.

Endovascular Aneurysm Repair procedures will remain at HRSRH.

Orthopaedic Surgery – Hips and Knees

Objectives:

- Standardized access for patients across the NE LHIN requiring assessment for primary hip or knee replacement facilitated through the use of a common referral form.
- Implementation of a web-based patient management system to track Wait 1 based on the Referral Tracking System.
- Timely patient access to a multidisciplinary assessment to facilitate triage based on a client's potential need for surgery.
- Reduction in wait times for hip and knee replacement surgery across the NE LHIN.

Update:

- The North East Hip and Knee Replacement Program (NE HKRP) has been implemented across the NE LHIN. The NE HKRP includes five Joint Assessment Centre sites – Hôpital régional de Sudbury Regional Hospital, North Bay General Hospital, Sault Area Hospital, Timmins and District Hospital and West Parry Sound Health Centre.
- A NE HKRP Coordinator has been hired and is responsible to coordinate the activities of the NE HKRP.
- A web-based referral and tracking system will be developed for the NE HKRP. The project is being led by HRSRH. In the interim the hospitals are using a modified version of the system developed by HRSRH.

Call schedule for urgent/emergent surgical care for the following areas:

- Orthopaedic
- Otolaryngology
- Plastics
- Urology

- Ophthalmology
- General surgery

Objectives:

- Identification of a coordinating mechanism and procedure to address regional call schedule.
- Identification of an online tool to be used to publicize call schedules and monitor gaps in call coverage in Northeastern Ontario.
- Identification of the role of hospitals of insufficient size to provide 24/7 coverage in order to maximize coverage provided, including holidays and weekends.

Update:

- Dr. Isser Dubinsky, Project Lead, and Dr. Tim Zmijowskyj, Project Associate, have been hired by the NE LHIN to work on the call schedule project.
- In the first phase of work, project team members have contacted several of the NE LHIN hospitals and physicians to gather additional information and schedule interviews for input on the process.
- Meetings with the specialty groups are nearing completion.
- Work on the second phase of the project has commenced. This includes the development of a framework for a call coverage model and the identification of an online tool to publicize call schedules and monitor gaps in call coverage in the North East.

Goals

The surgical optimization Steering Committee has developed a three year action plan to address the 33 recommendations stemming from the Surgical Optimization Report. The action is as follows:

Year 1 – 2011/12

- Thoracic surgical oncology – meeting Cancer Care Ontario (CCO) standards
- Orthopaedic – addressing wait time targets and repatriation issues

Year 2 – 2012/13

- HHR – development of a surgical health human resource plan
- Vascular surgery – plan to consolidate services
- Call schedules – implementation of call schedule strategies
- Call schedules – identification of coordinating mechanisms

Year 3 – 2013/14

- Itinerant surgeons – provision of directive for the use of itinerant surgeons
- HHR – roll-out of surgical human resource plan to address access to general surgeons across Northeastern Ontario
- Impact analysis – analysis of hospitals' ability to support their designated surgical role
- Integrated care pathways – promote the development of standard integrated pathways for common surgical procedures

Consistency with Government Priorities

Provincially, the Ontario government has been implementing a plan to increase access and reduce wait times for five major surgical services: cancer surgery, cardiac procedures, cataract surgery, hip

and knee replacements, as well as certain diagnostic exams. Many of the recommendations identified in the Surgical Optimization Report are directly linked to addressing the provincial priorities.

Action Plans/Interventions

Action Plans/Interventions	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Formalize regional diagnostic and surgical components of the Regional Thoracic Oncology Program as it pertains to SAH	100%		
Implementation of the NE HKRP	100%		
Develop framework to guide implementation of a regional call model	50%	50%	
Development of a NE LHIN surgical human resource plan (refer to HHR section for further details)		25%	25%
Implementation of call model for urgent/emergent surgical care			50%
Address request from SAH to enhance their vascular program within the context of creating a singular vascular program in Northeastern Ontario	100%		
Development of an integrated approach to care pathways between hospitals in Northeastern Ontario			25%
Mapping of surgical services in Northeastern Ontario as it relates to the appropriate distribution of resources and availability of services			25%

Measures of Success

- NE HKRP – will be measured through the Wait 1 and 2 information
- Regional Call – gaps in call schedules in Northeastern Ontario are identified and model developed to address service issues
- Vascular – agreement reached between the vascular surgeons on the delivery model for the SAH and HRSRH

What are the risks/barriers to successful implementation?

- Lack of financial resources to move recommendations forward
- Lack of human resources to respond to the needs of the NE LHIN surgical activities and ability to repatriate patients
- Resistance from the physicians to move forward with changing the way surgical services are being offered in Northeastern Ontario.

eHEALTH

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

The Ministry has identified eHealth and Information & Communication Technology as key focus areas, which the NE LHIN is currently supporting through our strategic priorities and activities in the IHSP. The NE LHIN has identified eHealth and Information & Communication Technology (ICT) as the key enabler to the nine NE LHIN priorities.

All of these areas are interconnected and interdependent. Within these priorities, we will seek to reinforce the need for prevention within our system wherever possible, enable and facilitate innovation, ensure smarter health care spending, and improve access to health care.

ICT solutions are key enablers for each of our nine priorities and will be leveraged to support service integration and the delivery of quality care. As with most health care initiatives, 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-agency or multi-sector partnership approach;
- Have a sound business case; and
- Can be used as foundational elements in the creation of an electronic health record.

eHealth and ICT involves the electronic enablement of health services to:

- Empower individuals and their families to manage their own health
- Improve the harmonization and integration of care delivery to patients
- Allow population health initiatives such as mapping chronic diseases (i.e. diabetes) to occur in a timely fashion
- Allow critical monitoring of chronic diseases to occur in a timely fashion leading to improved patient outcomes
- Enhance and enable the communication between health service providers, patients and care givers

Build on an eHealth Framework

In March 2009 the Ontario government released a provincial eHealth Strategy which focuses on: diabetes management, medication management, and wait times. Through information and communication technology investments that support clinical collaboration and seamless service delivery such as the diabetes registry, Wait Times Information System and electronic health records, the Ministry aims to improve access to information and support the delivery of high quality health care for patients across the province. eHealth is an enabler of every health service program and all nine of the IHSP priorities.

Current Status

Scope of services currently provided

- **eHealth and ICT** impacts all health services including: hospitals, physicians, specialists, FHT, FHN, FHG, community support services, independent health facilities (lab & diagnostic imaging), public health, pharmacy, community health centres, CCACs, mental health, addictions and long-term care.

Number of providers providing service

- **eHealth and ICT** impacts all health service providers including: specialists, physicians, pharmacies, Independent Health Facilities, Community Health Centres, Nurse Practitioners, community support services, CCAC sites, hospitals, public health units, long term care, FHT's, mental health and addictions. eHealth and ICT apply to all funded and non-funded HSPs.

Number and type of clients serviced annually

- **eHealth and ICT** assists health service providers, patients and clients through the whole continuum of care as eHealth initiatives are piloted, implemented and adopted.

Key issues facing this client group

Patient & Client Issues

- Duplicate and redundant information collected
- Referrals and matching appropriate resources to patients
- Lack of integration of information between hospitals, physician practices/CHC, CCACs and public health information, etc.
- Service delivery is complicated by geography, weather, lack of economies of scale and critical mass, dispersed populations, shortages of staff and resources
- Information privacy, security and consent
- Lack of understanding of eHealth and technology

Service Provider Issues

- Lack of electronic tools to communicate among themselves
- Diverse information management requirements of funders, and lack of integration between providers
- Silos of information management due to manual processes and a wide array of independent and non-integrated systems
- Lack of resources and support to identify and develop the opportunities to develop an electronic health record or health information system, especially for smaller organizations
- Differences in extent and use of automation
- Service delivery is complicated by geography, weather, lack of economies of scale and critical mass, dispersed populations, shortages of staff and resources
- Costs for smaller hospitals and community-based providers to advance and maintain their information systems in order to become part of a regional electronic health record is beyond their resource capacity

Projects:

- **Alternate Level of Care Resource Matching and Referral (RM&R) project –** The NE LHIN conducted a current state assessment mapping the current referral processes for transfer of ALC patients in the NE LHIN. Further, we collected organization specific current state

documents, tools and forms currently in use to support the referral and movement of ALC patients and defined and collected baseline metrics related to the transfer of ALC. Additionally an analysis of the data collected identified gaps and opportunities to assist in the design of a Future State. The scope for the initial NE LHIN ALC RM&R project focused on the following four pathways:

1. Acute care to Rehabilitation beds;
2. Acute care to Complex Continuing Care (CCC) beds;
3. Acute care to Long-Term Care (LTC) beds; and,
4. Acute care to Home Care

- **Pan Northern Ontario PACS ("PNOP") –** The PNOP project has recently been expanded to include the Champlain LHIN. As a result, the organization is now called the **Northern and Eastern Ontario Diagnostic Imaging Network (NEODIN).** This network will allow the sharing of images across the NE, NW and Champlain LHINs. The system will act as a back-up system for the Northern Hospitals, but will be the primary data source for the Champlain LHIN. As of March 2011, all sites in the NE LHIN are live.
- **Automation implementation** and upgrading continues in all sectors, including Family Health Teams, Independent Health Facilities, Public Health, Children's Treatment Centres, Long-Term Care Homes, and North East Ontario Network (NEON) membership.
- **Ontario Telemedicine Network (OTN)** continued with increases to access of all health service providers to its services. This fiscal, a joint OTN and NE LHIN regional plan was developed.
- **Physician Office Integration –** We are in the initial stages of working with North West LHIN to expand the Physician Integration solution, between hospitals and primary care providers/ CMS vendors.
- **Implementation and Adoption Readiness –** The LHIN has identified the need to increase their project management and change management capacity within their region. This project includes a study among the regional Health Service Provider (HSP) partners and assesses the current inventory of proven methodologies and tools which might be leveraged.
- **Ontario LHINs Privacy Project –** The NE LHIN provided all privacy and security materials and input into a 14 LHIN standardized approach when dealing with privacy, allowing for improved discussions and planning between health service providers and LHINs.
- **Doorways Project –** Lead a 4-LHIN (NE, NW, NSM, and Champlain) integration project with Ontario's Community Care Information Management (CCIM) to establish a provider portal to securely share and access accurate health information electronically. The objective is to conduct a pilot that integrates mental health and addictions data within a portal yielding clinical benefits and lessons learned through system to system integration. Currently there are 22 health service providers, 19 sites that are uploading data, and 822 users.
- **North East eHealth Advisory Council –** In support of a formal venue for cross-sector, cross-geographic eHealth collaboration system, the NEEAC met monthly to plan, guide and support eHealth initiatives in the NE LHIN.
- **Registered Nurses' Association of Ontario –** We have, through the Registered Nurses' Association of Ontario, brought awareness to all nursing communities of practice through a Nurse Peer eHealth Network which is a venue to provide input into the development of eHealth initiatives and deployment activities.
- **Shared Services Organization –** Developed a high level Shared Services model that has

been accepted by the majority of hospital Chief Executive Officers and work will continue to implement a Shared Services Organization.

- **EHealth team provided project delivery management and support for eHealth enabling technologies to support Integrated Health Services Plan priorities such as:** 1) the North East Hip and Knee Referral Program; 2) a Collaboration Site for NE LHIN health service providers; 3) Ontario Telemedicine Network end of life equipment; 4) Temiskaming Lab; and 5) Giiwednong Health Link Steering Committee involvement (14 First Nation providers developing an EMR).
- **ONE Network** is focused on the expected demand from the following initiatives: Telemedicine, Wait Times Information System expansion and physician clinical management system implementations. The attached point-in-time report identifies all sites within the NE LHIN, which shows that 351 are connected via a ONE Network circuit as of March 31, 2010.
- **Drug Profile Viewer –** 27 in Emergency Departments and 32 beyond the Emergency Department in the NE LHIN have installed the DPV. The goal of the DPV is to reduce the need for patients to give drug information to multiple care providers; potentially reduce the time needed for a medical assessment and allow for a faster diagnosis; improve the ability to avert potential adverse drug reactions and assess patient compliance and assure better continuity of pre-existing therapy, if required, when a patient is treated in hospital. The attached report identifies all hospital sites within the NE LHIN which have been deployed as of March 2010.
- **Network Refresh Project –** The Network Refresh Project (NRP) started in 2007 and was scheduled for completion by the end of fiscal 2008. Due to unexpected delays (e.g., construction), completion of all sites to their final solution was delayed, however 73 sites as of March 2010 were migrated.
- **Physician adoption of Electronic Medical Records (EMR) –** To date, 48% of eligible Primary Care Physicians were funded for IT/EMRs as were 8% of specialists (OntarioMD). A specific example, Group Health Centre in Sault Ste. Marie has been paper-less for 13 years.
- **Wait Time Information System/Emergency Department Reporting System/Critical Care Information System/Emergency Room National Ambulatory Care Reporting System Initiative** – hospitals in the NE LHIN are taking part in the provincial roll outs of these projects.
- **Communication –** The eHealth website page is updated regularly. Recently we established a “Did You Know” feature on eHealth that is part of the “Any News” bulletins.
- **Continuing Care Information Management (CCIM) –** Worked with CCIM on the deployment of electronic assessment tools and business systems that include MIS, HRIS, OCAN, and GAIN implementations for community support services, mental health and addictions, long-term care, community health services and small hospitals.
- **Diabetes Management Committee** developed in response to the growing demands that diabetes is placing on the health services in the North East LHIN. The Diabetes Management Committee (comprised of clinical and information systems leadership from across the region) will provide a system-level perspective to the NE LHIN on the planning and implementation of the Ontario Diabetes Strategy and the Diabetes Registry (DR) component on the Ontario eHealth Strategy.
- **Diabetes Registry –** The NE LHIN was identified as an early adopter of the provincial rollout of the provincial eHealth Strategy in 2008/2009. Deliverables met on the eHealth Ontario Diabetes Registry project included: development of project steering committee, diabetes design work plan, current state assessment, DR business model engagement and validation,

selection of leader sites and reporting. We completed the eHealth Ontario's Chronic Disease Management System Report and now await deployment plan.

- **ePrescribing Pilot Project –** The Group Health Centre (GHC) is one of only two sites which participated in the groundbreaking ePrescribing pilot project being hosted by MOHLTC and eHO in 09/10. The project is aligned with the Medication Management priority of the eHealth Strategy (on-line management of prescription medications) and has been extended into fiscal 10/11.
- **Network Management Services –** Engagement and integration of 29 HSPs in a shared service for network management and equipment standardization. Included in this project were the OTN Network Transition and the SSHA Network Refresh projects. Thunder Bay Regional Health Sciences Centre and Hôpital régional de Sudbury Regional Hospital are managing all 29 sites.

Goals

- Develop an integrated, sustainable shared service with hospitals across Northeastern Ontario
- Implement components of an Alternate Level of Care Resource Matching and Referral solution
- Foster integration, access and community engagement through the development of an Ontario Telemedicine Network regional plan and conference
- Strengthen community engagement and consultation processes with nurses
- Expand electronic medical records to community health service providers
- Deploy eHealth Ontario's Strategic Plan and funding deliverables

Consistency with Government Priorities:

The eHealth and ICT goals are aligned with the eHealth Ontario Strategy.

Action Plans/Interventions	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
Goal 1 A We will deliver a Shared Services Organization Steering Committee which will provide strategic guidance and operational direction, and an implementation approach towards the development of a Shared Services Organization	100		
Goal 1 B We will secure feasibility, analysis and implementation funding	30	35	35
Goal 1 C.		50	50

We will develop an Information Technology Shared Services Organization for hospitals			
Goal 2 We will implement recommendations from Phase 1 Alternate Level of Care Resource Management and Referral and further our future state definition, design and implementation planning and deployment within hospitals, Community Care Access Centre and long-term care	40	35	
Goal 3 We will develop an Ontario Telemedicine Network regional plan and coordinate a Northern Telemedicine Forum that includes the North West Local Health Integration Network	100		
Goal 4 We will continue, through the Registered Nurses' Association of Ontario, to bring awareness to all nursing communities of practice through a Nurse Peer eHealth Network which will be a venue to provide input into the development of eHealth initiatives and deployment activities	100		
Goal 5 We will expand electronic medical records within the community health service provider sectors in the NE LHIN	50	50	
Goal 6 A Physician Office Integration Project: We will finalize the expansion of the physician integration solution between hospitals and primary care physicians.	50		
Goal 6 B Doorways Project: We will finalize the establishment of system-to-system vertical integration via a portal across the NE, NW, NSM and Champlain LHIN with the existing pilot sites in 2011/12	65		

Goal 6 C We will work with eHealth Ontario to deliver the Diabetes Registry as it rolls out past the two early adopted LHINs	n/a	n/a	n/a
Goal 6 D Regional Integration Cornerstone Systems – We will work with eHealth Ontario to support the planning of regional and cornerstone information systems, referred to as Connecting Northern and Eastern Ontario (cNEO)	100		

Measures of Success

Increase in eHealth adoption as measured by new sites, users and systems

eHealth Strategy alignment

Completion of eHO project deliverables

An increase in the level of engagement in eHealth by health service providers (i.e. champions, partners, committees and organizations)

What are the risks/barriers to successful implementation?

A risk is whether the Ministry flows funds during 2011/13 fiscal; the plan will get revised as required.

A risk is whether eHealth Ontario will define future eHealth deliverables and/or flow funding to the LHINs.

Another risk is securing funding for the Shared Services Organization initiative through OntarioBuys or other sources.

INTEGRATION

TEMPLATE A: INTEGRATION
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

The NE LHIN supports integration initiatives that demonstrate action, priority setting and coordinated health service planning. While a number of integration priorities will continue to be led by the NE LHIN (e.g. wait times), other priorities will benefit from a community and hub area approach to achieve seamless and patient-focused health services that are planned and supported by partnerships.

The overarching goal of the NE LHIN Integration Strategy is to achieve the following outcomes at each of the community, hub area and regional levels: unity of governance, planning, action and evaluation leading to enhanced service delivery and sustainability.

Current Status

In 2011, the NE LHIN will strive to work in partnership to achieve successes with the following

projects:

- The creation of an Anchor Agency to integrate 129 addiction and mental health services currently being provided by 13 providers. It is expected that the agency will provide easier access to addiction and mental health services for consumers and their families. The NE LHIN will be monitoring the creation of the model closely and anticipates that the learning may be applied to adopt similar models across the region. The NE LHIN has engaged a project manager to oversee this important integration.

- The voluntary transfer the Esprit Place Sexual Assault Program from the District of Parry Sound Social Service Administration board to the Muskoka/Parry Sound Coordinated Sexual Assault Services. This integration, once approved at the NE LHIN, will result in a more streamlined approach to delivering sexual assault programs in Parry Sound.

  The NE LHIN has distributed an integration reporting template and self assessment template to all of the Health Service Providers. The reporting template will be submitted to the NE LHIN at the end of June 2011 and will identify the completed and current integrations projects.

Goals

The NE LHIN has completed community profiles of each of its 25 communities with a hospital. These profiles will serve as a basis for integration discussions within each community in May and June 2011. The goal of these sessions is to encourage communities and HSPs to look at ways to align the current services provided to the needs of the community. These discussions will lead to the identification of many integration opportunities.

The NE LHIN will work with the sectors to identify back-office opportunities. These back-office integrations will enable health service providers to maintain or enhance services. It will also improve the submissions of financial and statistical information which has been a challenge for many of our providers.

Consistency with Government Priorities

As described in LHSIA, integration is a key driver of health system transformation and is a shared responsibility between the LHIN, HSPs and the MOHLTC.

Action Plans/Interventions	Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column.		
	2011-12	2012-13	2013-14
North Bay General Hospital and Northeast Mental Health Centre	100%		
Esprit Place Sexual Assault and Parry Sound Coordinated Sexual Assault Services	100%		
MH Integration in Algoma Area	100%		

Expected Impacts of Key Action Items

- Enhance access to, and quality of, health services
- Improve individual and population health outcomes
- Improve the overall patient experience within the health system by reducing fragmentation and duplication
- Realize greater efficiencies through the most effective use of available resources
- Improve reporting

What are the risks/barriers to successful implementation?

- Resources available are insufficient to implement identified integration opportunities
- Resistance from interest groups (consumers, agencies & boards) who are happy with maintaining the status quo rather than moving forward towards a more integrated system
- The change management required is greater than anticipated

NE LHIN STAFFING AND OPERATIONS

PROPOSED OPERATING EXPENDITURES, PROJECTED REVENUES AND FUNDING REQUIREMENTS

Template B: LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2010/11 Actual	2010/11 Budget	2011/12 Planned Expenses	2012/13 Planned Expenses	2013/14 Planned Expenses
Salaries and Wages	2,671,788	2,734,474	3,036,078	3,036,078	3,036,078
Employee Benefits					
HOOPP	252,040	273,447	303,608	303,608	303,608
Other Benefits	279,041	300,413	333,969	333,969	333,969
Total Employee Benefits	***531,081***	***573,860***	***637,576***	***637,576***	***637,576***
Transportation and Communication					
Staff Travel	190,375	130,000	165,000	165,000	165,000
Governance Travel	55,156	60,000	65,300	65,300	65,300
Communications	93,224	90,000	60,000	60,000	60,000
Other	49,792	50,000	30,000	30,000	30,000
Total Transportation and Communication	***388,547***	***330,000***	***320,300***	***320,300***	***320,300***
Services					
Accommodation	171,625	213,931	177,430	177,430	177,430
Advertising	18,092	40,000	12,500	12,500	12,500
Banking	5	-	-	-	-
Consulting Fees	67,270	178,602	41,000	41,000	41,000
Equipment Rentals	16,085	18,000	20,000	20,000	20,000
Board Chair Per Diems	68,738	36,750	53,000	53,000	53,000
Other Governance Per Diems	29,532	88,050	41,800	41,800	41,800
Insurance	17,307	17,307	16,337	16,337	16,337
LSSO Shared Costs	409,495	359,495	359,495	359,495	359,495
LHIN Collaborative	50,000	50,000	50,000	50,000	50,000

Other Meeting Expenses	36,987	50,000	50,000	50,000	50,000
Other Governance Costs	40,991	20,000	29,800	29,800	29,800
Printing & Translation	68,855	65,000	77,500	77,500	77,500
Staff Development	20,778	40,000	30,000	30,000	30,000
Total Services	***1,015,760***	***1,177,135***	***958,862***	***958,862***	***958,862***
Supplies and Equipment					
IT Equipment	40,544	30,000	25,000	25,000	25,000
Office Supplies & Purchased Equipment	59,254	48,513	25,065	25,065	25,065
Total Supplies and Equipment	***99,798***	***78,513***	***50,065***	***50,065***	***50,065***
Capital Expenditures	***77,439***	***35,000***	***-***	***-***	***-***
LHIN Operations: Total Expenses	4,784,413	4,928,982	5,002,882	5,002,882	5,002,882
Annual Funding Target			5,002,882	5,002,882	5,002,882
Variance			-	-	-

NE LHIN STAFFING, IMPACT ON BUSINESS PLAN AND COMPENSATION STRATEGY

Template C: LHIN Staffing Plan (Full-Time Equivalents)				
Position Title	**2010/11 Actual as of March 31**	**2011/12 Forecast**	**2012/13 Forecast**	**2013/14 Forecast**
CEO	1	1	1	1
Senior Director	3	3	3	3
Administrative Support	6	6	6	6
Consultant	6	6	6	6
Senior Consultant	5	5	5	5
Board Liaison	1	1	1	1
Controller/Corporate Services Manager	1	1	1	1
Financial Analyst	3	3	3	3
Senior Aboriginal, First Nations, & Métis Advisor	1	1	1	1
Aboriginal Health Officer	0	1	1	1
Performance and Decision Support	1	1	1	1
Director, Communications and Community Engagement	1	1	1	1
Communications Officer-Multi Media	1	1	1	1
Chief Information Officer	1	1	1	1
Senior Project Manager	1	1	1	1
Project Manager	1	1	1	1
French Language Services Advisor	3	3	3	3
Total FTEs	**36**	**37**	**37**	**37**

Operational Impact

The NE LHIN has been working on a new organizational structure to enhance the ability to work with health service provider partners to meet 2011 priorities. In addition, we have spent much careful consideration in dividing our vast region into five HUB areas:

1. Sudbury/Manitoulin/Parry Sound
2. Nipissing
3. Algoma
4. Cochrane/Temiskaming
5. Hudson and James Bay Coast

The establishment of these HUBs was based on patient referral patterns. Small LHIN offices have been established in each of the four Hub areas (Hudson and James Bay will be served out of our Timmins and North Bay offices). These offices will allow our staff to have more frequent contact with the health service providers and community stakeholders.

We have also hired four additional experts on a contract basis to assist us with some of our important projects. A Project Manager has been hired for a year to oversee the Mental Health and Addiction integration project in the Algoma Area. Two physicians have been brought on to assist us with the development of a regional on call system. To assist us with implementing the new Assisted Living Policy, a one year contract position was implemented. This position will help us to identify community solutions to address the ALC pressures in our LHIN.

In 2011, the NE LHIN will be hosting community engagement sessions across the North East. The goal of the sessions is to seek input from health service providers and stakeholders in the community regarding the services provided in their area. The LHIN will be looking for opportunities to coordinate services in a more integrated and patient focused way with the existing funding. These engagements will require extension travel throughout the North East in the month of May and June.

We have negotiated the HSAA and MSAAs for 2011/12 and will be monitoring the outcomes on a quarterly basis. Dashboards for each health service provider will be established to guide these quarterly meetings.

In addition to the priorities outlined in our 2010/2013 Integrated Health Service Plan, our number one priority for 2011 continues to be ER/ALC. We will continue to work in partnership with hospitals, communities and the NE CCAC to help ease the ever-present ALC pressures in Northeastern Ontario. Given the importance of this file, a Senior Director has been assigned this portfolio. The Senior Director will continue to work with partners to achieve an overall ALC rate of 17% in 2011/12. Steering groups have been established in communities experiencing the greatest ALC pressures. The NE LHIN is pleased that we have been able to hire a consultant to work on the implementation of the Supportive Housing strategies.

Communication is an integral part of the NE LHIN and we ensure stakeholders receive information in a timely and easy-to-understand manner.

All of the strategies being implemented by the NE LHIN would not be possible without the support of our Project Management Office. Our CIO and her staff work diligently on implementing ways to use technology to reduce staff and board travel. They also assist in

many of our projects by implementing technologies that will provide seamless access to information.

COMMUNICATIONS AND COMMUNITY ENGAGEMENT PLAN

Objectives: What is the purpose of the ABP

The ABP is one of two guiding documents that are critical to the work of the NE LHIN; the other is the Integrated Health Service Plan 2010-13 (IHSP).

The IHSP guides the activities and accountabilities of local health service providers as described in the Local Health System Integration Act, 2006. Specifically, it provides an overview of the current health care system, identifies areas for focused improvement, and sets standards for achievement. All of this is done to advance the NE LHIN vision of 'Health and Wellness for All.'

The ABP demonstrates progress made toward reaching the IHSP's priorities, including:

- Aboriginal/First Nations/Métis Health Services
- Addiction and Mental Health Services
- Aging at Home
- Alternate Level of Care Strategies and Solutions
- Diabetes Care
- Emergency Department Wait Times
- French Language Health Services – An Integrated Approach
- Health Human Resources
- Optimization of Surgical Services

The ABP also provides the opportunity to fine tune strategies for the upcoming year. It provides a framework for communicating to stakeholders the impact local decision making has on health care delivery in our communities.

Context: Why do we do an ABP?

Under the Agency Establishment and Accountability Directive, LHINs are required to produce and publish a business plan annually. LHINs are also required to inform stakeholders about the LHIN's strategies and initiatives for addressing IHSP priorities. The NE LHIN's ABP communication plan ensures that all stakeholders have full and easy access to our strategic and operational plans. The document also includes an overview of the activities to support key provincial activities and a management plan to identify the future challenges faced by our health care system.

LHINs are responsible for engaging all stakeholders -- health care providers, consumers, and citizens at large in the work that is required to build an accessible and sustainable quality health care system.

The ABP also provides LHIN funding requirements for the next three years with particular focus on the 2011/12 fiscal year.

Target Audiences

Internal
Senior Management; Staff; Board of Directors; Ministry of Health and Long-Term Care, including: Minister's Office, LHIN Liaison Branch, LHIN Shared Services Office, Communications and Information Branch, other LHINs

External
Community at Large
Citizens, community leaders, consumers of health care, service clubs and organizations, and local media.

Special Population Groups
Francophone, Aboriginal/First Nations/Métis

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

Health Managers and Professions
LHIN Funded Health Service Providers: Hospitals; Specialty Mental Health Facility; Community Care Access Centre; Community Support Services; Community Mental Health, Addiction & Problem Gambling 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

Organizations: Local advocacy groups; College of Physicians and Surgeons of Ontario; Ontario College of Family Physicians; Ontario Medical Association; Ontario Public Health Association; Unions

Strategic Approach

Coordinated, same day release of ABP document for all LHINs (Date TBD).

Morning – LHINs to notify their provider/stakeholder groups

Afternoon – LHINs post on individual web sites. LHINs could issue local news release (optional)

Inclusion of ABP Goals and Action Plan in all on-going communication and community engagement activities.

Tactics

- Communication Partnership – Pan LHIN Communication Leads
- Developing strong local Government Relations – communicating LHIN priorities to MPPs through one-on-one meetings and regular communication
- Community Engagement – focusing on LHIN priorities in all community engagement efforts with stakeholders, including: physicians, community leaders, citizens, elected officials, regular meetings with sectors (HUBs, small hospitals, LTCH, CHC). In 2011, the NE LHIN is implementing its 2011/12 Communications and Community Engagement Plan which is focused on engaging with both communities and health service providers across the region. By the fall of 2011, more than 25 engagements will have been held with the objective of: 1) ensuring NE LHIN funded programs and services are aligned with the health care needs of people living in Northeastern Ontario; 2) ensuring NE LHIN strategies are in place to increase access to care, notably community-based care for fellow Northerners; and 3) leveraging integration opportunities within the NE LHIN HUB areas to ensure a patient-focused system of care
- Developing stories/articles that demonstrate how the ABP is put into action for the benefit of local citizens – through LHIN*fo* Minutes, NE-News, Website postings, and social media
- Maintaining proactive approach to media – highlighting NE LHIN initiatives in targeted local media a minimum of once/per week (All media relations activity is monitored and tracked)
- LHIN 101 – Weave ABP initiatives and priorities into LHIN 101 presentation and community engagement efforts
- Organizing Knowledge Building/Information Sharing Events
- Maintaining a consistent toolbox of communication vehicles
    - *2010-11 Annual Report*
    - *Media Releases*
    - *Blast emails*
    - *CEO's Blog – monthly Dear Northerners*
    - *NE LHIN Website*
        - Public Site
        - HSP collaborative work space
- Calendar of events posted to website
- LHIN*fo* Minutes – Bi-monthly one-page publication that focuses on LHIN work and how it benefits/plays a role in the lives of people
- Board Talk – monthly electronic highlight of NE LHIN activities for Board members
- Board Meeting Agenda items
- Social media – Facebook and twitter