North West **LHIN**

# North West Local Health Integration Network

## Final Submission

# Annual Business Plan

**2012 - 2013**

**June 4, 2012**

Ontario
Local Health Integration Network

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# Annual Business Plan 2012-2013

## 1.0 Context

### 1.1 Transmittal Letter

Alex Bezzina, Deputy Minister,
Health System Accountability and Planning Division
Ministry of Health and Long-Term Care

Dear Mr. Bezzina:

I am pleased to provide you with the *North West Local Health Integration Network Annual Business Plan 2012-13*. The Plan demonstrates how the North West Local Health Integration Network (LHIN) plans to improve the health system in Northwestern Ontario.

Our LHIN has focused its efforts in the areas of:

- Collaborating with our health service providers to advance the *Integrated Health Services Plan* (2010-2013) priorities;
- Supporting key Ministry of Health and Long-Term Care priorities such as emergency department wait times, alternate level of care, diabetes strategy and mental health and addictions;
- Building a comprehensive chronic disease prevention and management strategy; and,
- Implementing our e-Health plan.

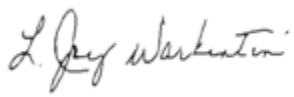
In advancing these initiatives, the North West LHIN has engaged stakeholders, built capacity and funded innovative solutions and strategies.

The Annual Business Plan, one of two components of the Annual Service Plan, details the LHIN's multi-year plans for the local health system and describes how the North West LHIN is progressing with our Integrated Health Services Plan (IHSP). It is submitted in accordance with the reporting requirements established in the *Local Health System Integration Act*, 2006 and the Agency Establishment and Accountability Directive.

The Annual Business Plan has been reviewed by the North West LHIN's Board of Directors and the following resolution was passed January, 31, 2012 *"The North West LHIN Board of Directors approves the North West Local Health Integration Network Annual Business Plan 2012-13."*

We believe that the *North West Local Health Integration Network Annual Business Plan 2012-13* will assist the North West LHIN in achieving our vision, "Healthier people, a strong health system – our future".

If you have any questions or comments regarding the Plan, please contact Laura Kokocinski at (807) 684-9425.



L. Joy Warkentin
Board Chair

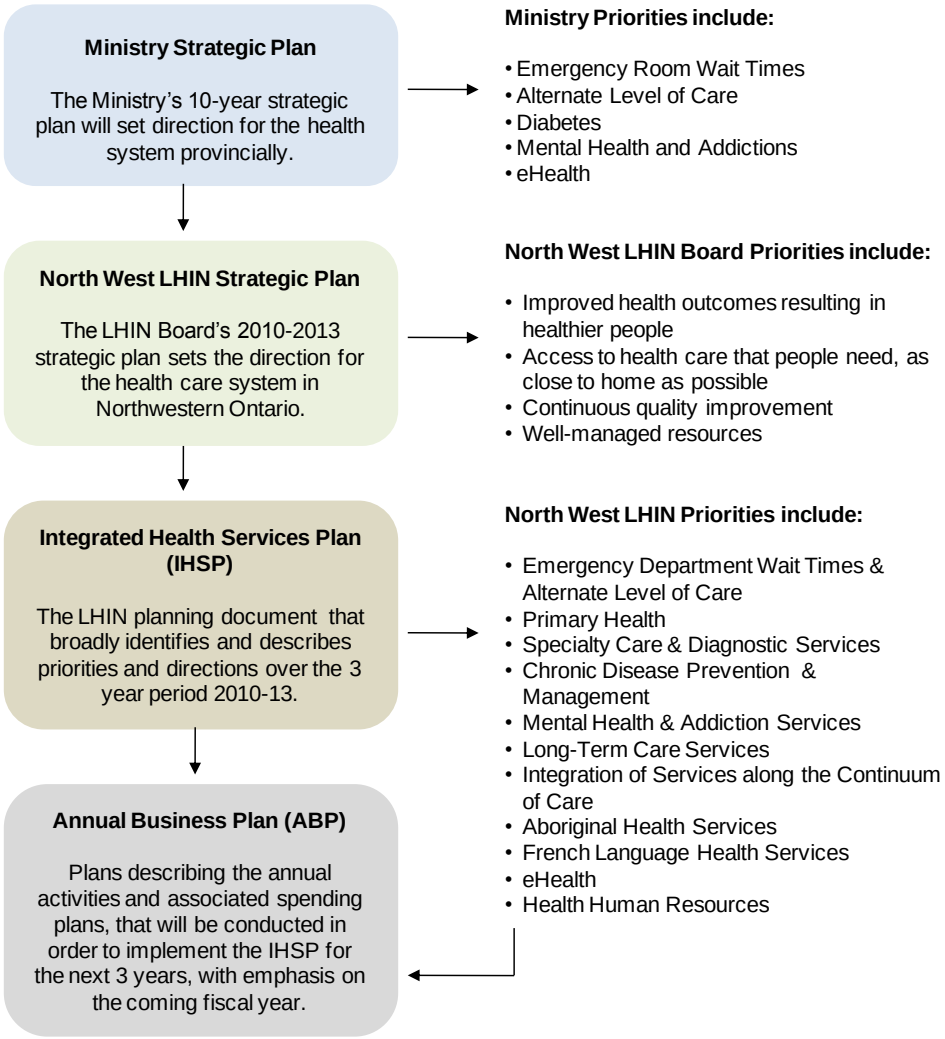
## 1.2 Mandate

The North West Local Health Integration Network (LHIN) is a crown agency mandated to plan, fund and integrate the local health system as articulated in the *Local Health System Integration Act, 2006.*

## 1.3 Strategic Plan

The North West LHIN's vision is, "Healthier people, a strong health system – our future." In 2009, the North West LHIN Board of Directors undertook an extensive strategic direction planning exercise, resulting in the approval of *Leading Health Systems Transformation in our Communities: 2010 to 2013 North West LHIN Strategic Directions*. The strategic directions and the Integrated Health Services Plan (IHSP) align with the Ministry of Health and Long-Term Care's (MOHLTC) strategic priority areas and are implemented through the North West LHIN's Annual Business Plan as Illustrated below.

Figure 1: Relationship between MOHLTC Directions, North West Local Health Integration Network Strategic Directions, IHSP Priorities and Annual Business Plan.



### 1.4 Overview of Current and Forthcoming Programs and Activities

The North West LHIN plans, funds and integrates local health services. The North West LHIN does not provide health care services, but works with health service providers and community members to set priorities and plan health services in Northwestern Ontario. The North West LHIN allocates funding to 95 health service providers who provide the following programs:

- Hospitals (13);
- Community Care Access Centre (CCAC) (1);
- Community support services (62);
- Long-term care (15);
- Community Health Centres (CHCs) (2); and,
- Community mental health and addictions services (35).

The North West LHIN aims to improve the quality and accessibility of health care for all residents of Northwestern Ontario through better integration and coordination of services across the system.

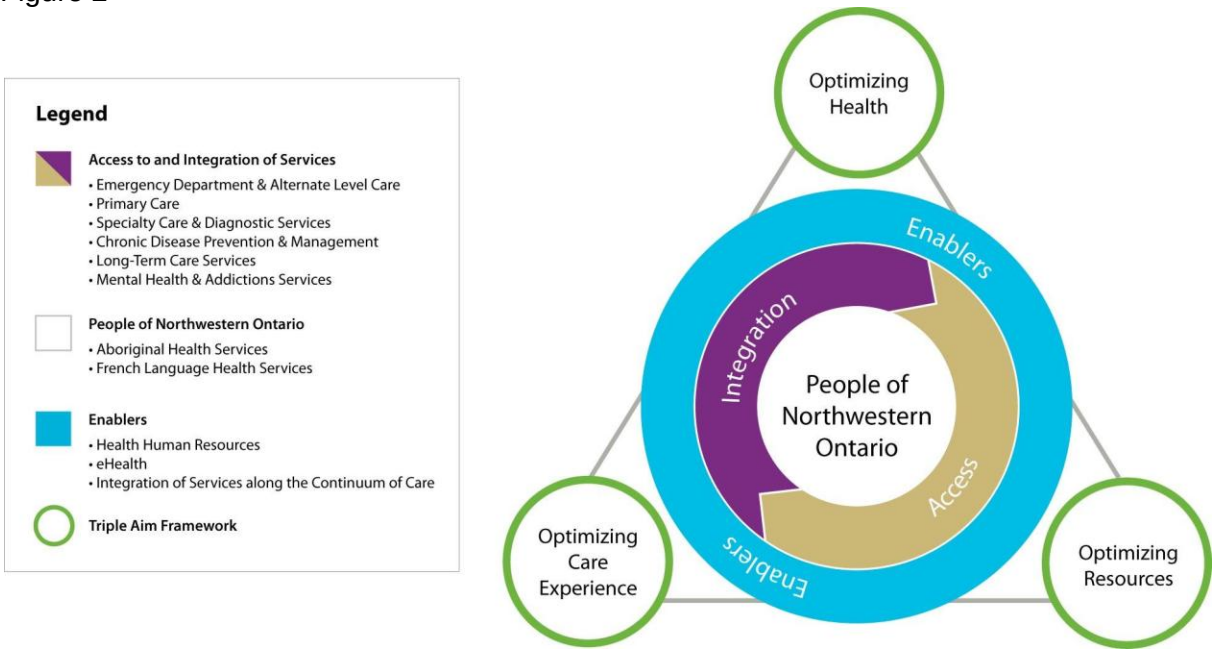
The plans outlined in the North West LHIN's second IHSP are aligned with the overall goals of the Triple Aim Framework (see Figure 2 below):

1. Optimizing Health (population health);
2. Optimizing Care Experience (patient satisfaction); and,
3. Optimizing Resources (per capita cost).

The priorities of the IHSP are focused in three primary areas:

1. Access to and Integration of Services;
2. People of Northwestern Ontario; and,
3. Enablers.

Figure 2



***Access to and Integration of Services:***

The following priorities for change will guide the activities of the North West LHIN.

Emergency Department Wait Times and Alternate Level of Care: Transitioning patients through the health care system without delay will free up beds for those recovering from elective surgery or waiting in emergency departments for admission. Creating more alternatives for patients with or without a family doctor for non-urgent health issues will help reduce the number of visits to emergency departments.

Primary Care: Models of care that improve access to a team of professionals will increase access to and improve quality of care. With the vital role primary care plays in the health system, improving access to services will result in better health outcomes, improved quality of care and integration along the continuum of care.

Specialty Care and Diagnostic Services: Better access to specialty care and diagnostic services will result in improved outcomes for clients and higher client satisfaction.

Chronic Disease Prevention and Management: By focusing on chronic disease management through improvements in access to primary care and expansion of chronic disease prevention and self-management programs there will be a decrease in ED visits, admissions to hospital and readmission rates.

Long-Term Care Services: Improving access to long-term care services for individuals with moderate to high care needs will help the people who require these services to live independently and with dignity.

Mental Health and Addictions Services: Improving access to and coordination of mental health and addictions services will improve quality of life and care for those requiring service. It will also help prevent conditions from getting worse, which results in longer-term medical needs and social problems.

***People of Northwestern Ontario:***

The following population characteristics will guide the activities of the North West LHIN.

Aboriginal Health Services: Important health gains can be achieved by increasing and improving the delivery of health services in Aboriginal communities and providing appropriate linguistic and cultural services to increase patient satisfaction, safety and quality of life.

French Language Health Services: By improving access to health services for the Francophone population in Northwestern Ontario, the care experience and health outcomes will improve.

***Enablers:***

The North West LHIN will continue advancing these enablers in 2012-2013 and beyond.

Health Human Resources: Promoting interprofessional care (a team approach to patient care) will allow clinicians to maximize their time and skills and reach out to more of the population.

eHealth: The sharing of patient information along the continuum of care and across communities will allow health service providers to improve the quality and efficiency of care and minimize duplication and potential errors.

Integration of Services along the Continuum of Care: Better communication and coordination of care between and across sectors will help to improve patient access, reduce duplication of health care services, improve health outcomes and improve client satisfaction.

**1.5 Environmental Scan**

***Environmental Scan:***

The North West LHIN faces many challenges in the delivery of health care services. Some of these challenges are listed below.

Compared to the rest of Ontario, the North West LHIN has:

- The largest geographic area (47% of the province);
- The lowest population (approximately 235,000 people with almost half living in the City of Thunder Bay);
- The highest rate of non-urgent emergency department visits (209 per 1,000 population vs. 40/1,000 provincially);
- A slightly higher proportion of people 65 years and older; and,
- The highest percentage of Aboriginal peoples (19.2%).

***Health Status of Northwestern Ontario[1]:***

Relative to the rest of the province, the North West LHIN has a higher:

- Proportion who smoke (25.3% versus 18.6%);
- Proportion of heavy drinkers (21.8% versus 15.6%);
- Percentage (age 15+) who are overweight/obese (60.6% versus 51.4%); and,
- Prevalence of many chronic conditions including arthritis (23.3% versus 17.1%), high blood pressure (20.8% versus 17.6%) and diabetes age 65+ (51.5% versus 46.9%).

And a lower:

- Percentage having contact with a medical doctor in past year (78.8% versus 82.9%);
- Life expectancy for females and males (81.0 years versus 83.1 years, and 76.1 years versus 78.8 years respectively); and,
- Proportion reporting self-rated health as “excellent” or “very good” (58.2% versus 61.2%).

[1] Based on 2009 Canadian Community Health Survey results for individuals aged 12+

Cost drivers associated with our population characteristics include:

- Low socioeconomic status, poor lifestyle behaviours, poor health status, decreased availability of informal caregivers and an aging population will increase the reliance on health care services;
- Securing skilled caregivers is an increasing challenge for many communities and seniors in the Northwest;
- Declining population will lead to further diseconomies of scale; and,
- Declining local economy will present challenges for local fundraising and sponsorships.

***Strengths in Northwestern Ontario:***

While the North West LHIN faces challenges, it also benefits from some important strengths:

Technology: Those living in the Northwest are leaders at using technology to improve access to care.

Partnerships: People living in Northwestern Ontario have a history of working together to meet the needs of their clients.

Innovation: The Northwest continues to be recognized for its innovation provincially, nationally and internationally. Planning for and providing care in remote and rural northern communities, results in the need to try new things to meet the needs of our region (i.e. service provision, health human resource planning and training).

# 2.0 Core Content

### 2.1 Priority 1: Emergency Department Wait Times and Alternate Level of Care

| PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY |
|---|
| Integrated Health Services Priority: |
| Priority 1: Emergency Department Wait Times and Alternate Level of Care |
| IHSP Priority Description: |
| To improve health system performance and integrate care for the patient/client in the right setting, at the right time, by the right provider. |
| Current Status: |

- The North West LHIN has three hospitals reporting Emergency Department (ED) wait times (Thunder Bay Regional Health Sciences Centre, Dryden Regional Health Centre and Lake of the Woods District Hospital). In 2010-11, these EDs handled 141,993 ED visits. Of the over 141,993 ED visits, 78% were seen in the tertiary centre at Thunder Bay Regional Health Sciences Centre (TBRHSC).
- In 2010/11, 49% of all ED visits in the North West LHIN were classified as Canadian Emergency Department Triage and Acuity Scale (CTAS) 4 and 5 (low acuity). Primary care is provided in EDs outside of Thunder Bay where limited walk-in or after-hour clinics exist.
- ED visit rates per 1,000 people in the North West LHIN are double the provincial average and readmission rates are higher for certain ambulatory sensitive conditions such as Chronic Obstructive Lung Disease, Congestive Heart Failure, Diabetes and Pneumonia.
- The length of stay in the Emergency Department (ED) and Alternate Level of Care (ALC) are concerns in larger communities, particularly in the City of Thunder Bay and Kenora.
- Trends in Q1 2011/12 demonstrate the following:
    - 90% of patients are admitted in 29.8 hours or less;
    - 90% of admitted patients reach an inpatient bed within 19.3 hours;
    - 90% of non-admitted patients with a more complex condition are discharged from hospital within 6.6 hours;
    - 90% of non-admitted patients with a lower acuity condition are discharged from hospital in 3.9 hours or less; and,
    - 90% of patients see a physician within 2.3 hours or less of their visit to the emergency department.
- Lack of access to primary care and limited community supports (i.e. supportive housing,

assisted living and services as homemaking, transportation, etc.) are system challenges that contribute to ALC days in the North West LHIN. The North West LHIN continues to make investments to enhance community support services.

- The percentage of ALC days is the third highest among the LHINs in the province (17.44% as of Q1 2011/12).
- Implementation of Home First in the City of Thunder Bay has resulted in the following from September 2010 – November 2011:
  - 36% reduction in ALC patients waiting in hospital;
  - 33% reduction in patients waiting for long-term care in hospital;
  - Joint planning between the acute care setting, North West CCAC and North West LHIN is underway for implementation of Home First in the City of Kenora;
  - Four Assess and Restore pilots are underway in communities across the North West LHIN; and,
  - Increased supportive housing services will be made available in three communities across the North West LHIN.

Successes of the past year:

- Remained a high performer with ED wait times for high and low acuity non-admitted patients.
- Decreased wait times for in-home care services through the North West CCAC.
- Implemented evidence-based, common order sets for admitted patients at nine community hospitals in our region.
- Developed and implemented standardized coding and triage reference guidelines in all hospitals in the North West LHIN.
- Implemented joint discharge planning in the City of Thunder Bay between acute, post-acute setting, and North West CCAC through Home First.
- Invested in increased community support services across the LHIN.
- Increased and enhanced services offered by North West CCAC.
- Increased supportive housing services in five communities.
- Increased transitional care bed capacity by 20 beds in Thunder Bay.
- Increased interim long-term bed capacity in Kenora (10 beds).
- Increased long-term capacity in Terrace Bay (22 beds).
- Implemented expanded role of the Community Care Access Centre in:
  a) two acute care settings through Home First;
  b) all Adult Day Programs; and,
  c) three Supportive Housing sites in our region.

## PART 2: GOALS and ACTION PLANS

Goal(s)

1. Reduce unnecessary Emergency Department visits.
2. Reduce the time spent waiting in the Emergency Department.
3. Improve bed utilization and patient flow across the system.
4. Improve patient/family satisfaction with the care experience.

Consistency with Government Priorities:

*Leading Health System Transformation in our Communities: 2010 to 2013, North West LHIN Strategic Direction*s and the North West LHIN's IHSP closely align with and support the provincial directions of the Ministry of Health and Long-Term Care (MOHLTC) and focus on:

- Improving access to Emergency Department (ED) care by reducing the amount of time that patients spent waiting in ED;
- Improving access to hospital care by reducing the time spent designated as Alternate Level of Care (ALC) patients in hospital beds; and,
- Improving the patient care experience.

Action Plans/Interventions

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next three years with concentration on those actions that will be largely implemented within the upcoming year.

| Action Plans<br>"We will deliver the following" | Please indicate the status of project (Not Yet Started, In Progress, Deferred or Completed) and, if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column. | | | | | |
|---|---|---|---|---|---|---|
| | 2012/13 | | 2013/14 | | 2014/15 | |
| | Status | % | Status | % | Status | % |
| Reduce emergency room visits and readmission rates by 5% for select CMGs via chronic disease prevention and management strategies and decrease ED visit rates for mental health and addictions clients through targeted strategies. | In progress | 10% | In progress | 15% | In progress | 50% |
| Evaluate and expand Assess and Restore model to address ALC pressures. | In progress | 25% | Completed | 75% | | |
| Implement the Emergency Department Pay/For Results (P4R) at the high volume hospital site in the North West LHIN. | In progress | 25% | In progress | 25% | Completed | 50% |
| Create transitional and permanent long-term care space in the community. | In progress | 25% | In progress | 25% | In progress | 25% |
| Create long-term capacity for quality improvement within hospitals and the CCAC setting in the North West LHIN (i.e. through spread of the Flo Collaborative work). | In progress | 33% | In progress | 33% | Completed | 34% |
| Advance the recommendations of | In | 33% | In | 33% | Completed | 34% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| the Regional ED Study, including improving access to transportation services for medical purposes across the North West LHIN. | progress | | progress | | | | |
| Implement Home First across the North West LHIN where appropriate. | In progress | 33% | In progress | 33% | Completed | 34% | |
| Achieve and advance the following recommendations from Dr. Walker's report:<br>▪ Group home models in the northwest (R.7);<br>▪ ALC Long case investments (R.8);<br>▪ Senior Friendly Hospital (R.11); and,<br>Best practice for rehabilitation (R.18 & 19). | In progress | 25% | In progress | 25% | In progress | 25% | |
| Continue implementation of the expanded role of CCAC. | In progress | 33% | Completed | 50% | | | |

How will we measure success?

- Assess Restore units will service 92 clients annually based on a maximum LOS of 90 days and will reduce alternate level of care days at those hospital sites;
- Evaluate action plans, monitor/track improvement in ED wait times;
- Create or shift capacity from hospital to community-based care to decrease ALC days;
- Effectively reduce alternate level of care days to ensure system flow; and,
- Improve patient transitions across the care continuum.

What are the risks/barriers to successful implementation?

Lack of access to primary care and limited community services (i.e. supportive housing, assisted living and support services such as homemaking, transportation, etc.) are system barriers that impact ED wait times and Alternate Level of Care (ALC) days in the North West LHIN.

Health human resource limitations could pose challenges to expansion to community-based care.

What are some of the key enablers that would allow us to achieve our goal?

Home First, Expanded Role of North West CCAC, Alternate Level of Care Community Funding and Collaborative partnerships between service providers

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

### 2.2 Priority 2: Primary Care

| PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY |
|---|
| Integrated Health Services Priority: |
| Priority 2: Primary Care |
| IHSP Priority Description: |
| To increase access to primary health care. |
| Current Status: |

In the North West LHIN, residents access primary care in the following locations (where available, the number of services are provided in brackets):

- Clinics (solo or group practice);
- Family Health Teams (14);
- Nurse Practitioner Clinics (2 announced to open in Thunder Bay during 2010-11);
- Community Health Centres (2 plus 2 satellite offices and 2 mobile units);
- Aboriginal Health Access Centres (3);
- Federal Nursing Stations (24);
- Walk-In Clinics (available only in Thunder Bay);
- Emergency Departments (12); and,
- Maternity Centre and Midwifery Clinic (both in Thunder Bay).

Difficulty accessing primary care results in high rates of inpatient and emergency department care.

Within the Northwest:

- There are an estimated 13.2% (versus 7.0% provincially) unattached patients age 16 and older (the highest for all LHINs per capita).
- Residents report the lowest rates in the province for access to a medical doctor (83.4%) and consultation with a medical doctor (78.8%).
- Only residents in the City of Thunder Bay receive more than 90% of their primary care physician services in their own sub-area.
- Primary care providers may have to travel to remote communities and the travel time reduces their clinical hours.
- Practitioners in smaller communities are likely to take on different roles (i.e. ED coverage, Chief of Staff, anaesthesia), reducing the amount of time they are providing primary care services.
- Over 122,000 primary care visits are provided per year in remote First Nations nursing stations, funded by Health Canada.
- The Northwest has the highest rate of non-urgent visits to the emergency department in the province.

- There are less people with diabetes who are able to access a family physician, resulting in

higher utilization of the emergency department (531/100,000 visits in the Northwest vs. 232/100,000 provincially) and increased hospitalizations (236/100,000 separations vs. 103/100,000 in Ontario).
- The North West LHIN has the highest unscheduled emergency department visit rate of all LHINs at 209 per 1,000 population.
- Access to care improved as a result of the 20,000 visits through telemedicine

Successes in the past year:
- Two new Family Health Teams (FHTs) have opened: one in Nipigon and one in Manitouwadge. Harbourview FHT in Thunder Bay has been announced and will open in 2012.
- Since the opening of the Lakehead Nurse Practitioner-Led Clinic, the clinic has rostered over 1,000 patients
- Anishnawbe Mushkiki Aboriginal Health Access Centre's NP-Led clinic is due to open in 2012.
- The Healthcare Connect program operated by the North West Community Care Access Centre has helped refer 37% of registered individuals (unattached patients) to health care providers in the community of Thunder Bay (as of December 2012).
- Improved access to interprofessional care through Family Health Teams and mobile services available through Community Health Centres.
- Increased support for self-management of chronic diseases through training of health service providers and community members.
- Supported quality improvement through Quality Improvement Innovation Partnership (QIIP) work with Family Health Teams.

## PART 2: GOALS and ACTION PLANS

Goal(s)

1. Increase the percentage of the population with regular access to a primary health care provider or team of primary health care providers.
2. Improve integration between hospitals and primary care delivery in smaller communities.
3. Reduce emergency department visits and avoidable admissions to hospital.
4. Improve timely access to primary care services (i.e. same day access initiatives).

Consistency with Government Priorities:

These objectives will help to:
- Reduce emergency department wait times;
- Improve health outcomes for diabetic patients;
- Increase access to family health care; and,
- Improve health outcomes for those with mental health and addictions issues.

Action Plans/Interventions

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next three years with concentration on those actions that will be largely implemented within the upcoming year.

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|---|---|---|---|---|---|---|
| | 2012/13 | | 2013/14 | | 2014/15 | |
| | Status | % | Status | % | Status | % |
| Promote implementation of new primary health care initiatives:<br>▪ FHT<br>▪ NP Led Clinic<br>▪ Health Care Connect | In progress | 33% | In progress | 33% | Completed | 34% |
| Expand primary care delivery through telemedicine, telehomecare, outreach and mobile services. | In progress | 33% | In progress | 33% | Completed | 34% |
| Hire and support the work of a Primary Care Physician Lead in advancing integrated clinical practice approaches to care delivery in the community. | In progress | 33% | In progress | 33% | Completed | 34% |
| Develop innovative strategies for health service providers to work at their full scope of practice. | Ongoing | | Ongoing | % | Ongoing | |

How will we measure success?

As a result of these activities, it is expected that a greater number of individuals living in the Northwest will be rostered to a primary care provider (physician or nurse practitioner), that the number of telemedicine events for primary care will be increased and that improved access to primary care will support other intiatives such as reducing ED wait times and improving chronic disease prevention and management.

What are the risks/barriers to successful implementation?

Retention and recruitment of physicians is a challenge in nearly all communities in the North West LHIN. Maintaining primary care (and emergency) services can be difficult when there is a vacancy, especially given the dependence on one practitioner. The LHIN has no responsibility for physician recrutiment or retention, but health service planning across the continuum is greatly affected by access to primary health care.

| What are some of the key enablers that would allow us to achieve our goal? |
|---|
| Family Health Teams and interprofessional teams support access to primary care. Increased supports for telemedicine will also improve access, especially where specific services (i.e. dietetics, speech pathology, rehabilitation services etc.) may not be available locally. |
| Additional Comments (i.e. additional information that supports the implementation/success of the goal) |
| |

### 2.3 Priority 3: Specialty Care and Diagnostic Services

| PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY |
|---|
| Integrated Health Services Priority: |
| Priority 3: Specialty Care and Diagnostic Services |
| IHSP Priority Description: |
| To improve access to specialty care and diagnostic services. Items included under specialty care include surgical and diagnostic imaging services funded through the Ontario Wait Times Strategy Project. |
| Current Status: |

Over the past several years, the North West LHIN has improved access to services and, as a result, has seen improvements in the waits experienced by patients. The performance of the North West LHIN for the current year is illustrated below:

| Performance Indicator | Provincial Target | LHIN Starting Point 2011/12 | July – Sept, 2011 Performance |
|---|---|---|---|
| 90th Percentile Wait Times for Cancer Surgery | 84 Days | 37 days | 41 days |
| 90th Percentile Wait Times for Cataract Surgery | 182 Days | 86 days | 103 days |
| 90th Percentile Wait Times for Hip Replacement | 182 Days | 171 days | 167 days |
| 90th Percentile Wait Times for Knee Replacement | 182 Days | 183 days | 216 days |
| 90th Percentile Wait Times for MRI Scan | 28 Days | 87 days | 77 days |
| 90th Percentile Wait Times for CT Scan | 28 Days | 28 days | 35 days |

Over the past several months, the LHIN has seen sustained high performance in the areas of Cancer, Cataract and Hip Replacement.

The area where the LHIN is experiencing some difficulty is wait times at the 90th percentile for knee

replacement surgery. The LHIN has seen some improvements as a result of the Regional Joint Assessment Centre (RJAC) becoming more broadly utilized. To address the long wait times for knee replacement, the LHIN is working with the hospitals and specific surgeons to develop and implement strategies to reduce these wait times.

Wait times for diagnostic imaging in the North West LHIN have been adversely impacted by reductions in funded volumes. Over the past three years, the North West LHIN has seen the funding through the Ontario Wait Time Strategy reduced by approximately 25%. This, coupled with increased demand for scans has resulted in an increase in wait times. The LHIN is working with hopsitals to examine opportunites to improve diagnostic imaging utilization.

Specialist services in the LHIN span beyond those areas considered under the wait time strategy. Items considered specialty services include any medical services that do not fall under the category of general practitioner services.

The North West LHIN is working with physicians and health service providers to reduce the length of stay for unilateral hip and knee surgery and stroke patients.

**PART 2: GOALS and ACTION PLANS**

Goal(s)

1. Reduce access barriers to specialty care and diagnostic services.
2. Reduce wait times for procedures included in the wait times strategy (i.e. hip and knee replacement surgery, cataract surgery, cancer surgery, pediatric surgery, general surgery and diagnostic services).
3. Improve system readiness for surge capacity in critical care due to pandemic or other events.
4. Reduce time spent (wait times) in the emergency department.

Consistency with Government Priorities:

Wait times has been identified as a priority of the government. The North West LHIN is committed to ensuring that our performance is consistent with the provincial targets as outlined through the Ministry/LHIN Performance Agreement (MLPA).

Action Plans/Interventions

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|---|---|---|---|---|---|---|
| | 2012/13 | | 2013/14 | | 2014/15 | |
| | Status | % | Status | % | Status | % |
| Engage stakeholders, analyze options for and make recommendations for the development and implementation of a regional surgical network. | Not Yet Started | 25% | In progress | 25% | Completed | 50% |
| Evaluate the effectiveness of the Regional Joint Assessment model and advocate for the expanded presence of similar service delivery models across additional surgical procedures. | In progress | 25% | In progress | 25% | In progress | 25% |
| | | | | | | |
| Work with Thunder Bay Regional Health Sciences Centre to take the lessons learned from the MRI Process Improvement Program (PIP) and apply these learnings to other diagnostic imaging procedures (i.e. CT scans). | Not Yet Started | 25% | In progress | 25% | In progress | 25% |
| Work with tertiary hospital through P4R Action Plan to reduce time to consult by specialist. | In progress | 50% | Completed | 50% | | |
| Improve orthopaedic length of stay through targeted initiatives. | In progress | 25% | Completed | 75% | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Develop an emergency preparedness plan for the North West LHIN. | Completed | 100% | | | | |

How will we measure success?

As a result of these activities, it is expected that the LHIN will be positioned to meet its MLPA targets for wait times. The continuous evaluation of the wait times programs operated in hospitals in the North West LHIN will ensure that programs achieve ongoing improvement in wait times and quality of care. This evaluation will ensure that the system is structured to ensure services are offered in the appropriate place to the appropriate population. See the above table in "Current Status" section for the appropriate performance metrics.

The importance of these continuous improvement initiatives are highlighted by the fact that demand for surgical and diagnostic services is increasing and the resources dedicated for incremental procedures is decreasing.

What are the risks/barriers to successful implementation?

Funding for wait times services is provided on a one-time basis and is not guaranteed in future years. Also, some hospitals do not have base wait time funding. Where wait times funding is reduced, waits for all of the procedures noted above will increase as the case volume will decrease. In 2011/12, the North West LHIN saw a significant reduction in the funded volume of several procedures which has resulted in increased wait times.

Additionally, in the North West LHIN, the large geography makes concentrating services difficult as it limits the patients ability to access care close to home. As such, in many cases, some services are offered in small hopsitals in the North West that would not be offered in other areas of the province. When citing services, the LHIN must consider the trade off between providing access to care close to home and creating a program that has sufficient volume to be financially and clinically feasible.

What are some of the key enablers that would allow us to achieve our goal?

In the short term, sustaining funding levels for services is critical to the achievement of our goals. With sustained operating funding, hospitals will be able to continue to offer services in the interim while undertaking the transformational activities noted above that are required for long-term sustainability.

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

### 2.4 Priority 4: Chronic Disease Prevention and Management

| PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY |
|---|
| Integrated Health Services Priority: |
| Priority 4: Chronic Disease Prevention and Management |
| IHSP Priority Description: |
| To improve chronic disease prevention and management (CDPM), through the creation of a culture of enhanced personal responsibility for health and the implementation of evidence-based practices. |
| Current Status: |
| The population of the North West LHIN experiences increased prevalence and earlier onset of many chronic diseases when compared with the rest of the province. It is estimated that approximately 100,000 people in the North West LHIN live with a chronic disease. Rates of diabetes in the Aboriginal population are estimated to be two – three times higher than in the general population.<br><br>It is recognized that a disproportionate number of people manage chronic conditions in the acute care setting in the North West LHIN. ED visits, acute admissions, readmission rates and in many cases, length of stay, exceed the provincial average. In an extensive planning initiative currently underway, the need for additional supports to manage chronic conditions in the community was clearly identified.<br><br>Across the North West LHIN, many health service providers deliver chronic disease prevention and management services including, but not limited to; hospitals, the Community Care Access Centre, two Community Health Centres, long-term care homes, community agencies and primary care practices. The North West LHIN supports the regional networks that are in place to better integrate patient care in the areas of stroke management, renal services, dementia care, diabetes and chronic disease self-management.<br><br>In the fall of 2011, the North West LHIN successfully transitioned chronic disease self-management programs to the management of the North West CCAC. A centralized intake has been developed and the program has been branded regionally. Mentoring in self-management has been provided for clinicians in a variety of settings to enhance capacity. Recently, funding for self-management services became a provincial initiative through the Ontario Diabetes Strategy. As a provincial leader in this area, the North West LHIN was represented on the provincial working group which helped to inform the provincial direction.<br><br>To support people with congestive heart failure and chronic obstructive pulmonary disease, a regional telehomecare program was established the spring of 2011. These programs are supported by a nurse practitioner, a pharmacist and a respiratory therapist who have the capacity to monitor patient status and make real-time changes to better manage these chronic diseases in patients' homes. It is anticipated that use of acute care services will be reduced by a minimum of 20% in the population served by these programs in the first year.<br><br>The NorWest CHC mobile unit for diabetes care continues to provide access to primary care in nine |

rural communities in the North West LHIN. In addition to primary care, this program offers foot care which helps to address the high number of diabetic wounds and amputations in Northwestern Ontario.

Access to quality care for chronic disease management in the community continues to be a challenge in the rural/remote context of the North West LHIN.

Key issues affecting improved outcomes for people with chronic disease include:

- Access to primary and specialty care;
- Lifestyle choices leading to poor health outcomes and early onset of chronic conditions (rates of smoking, alcohol consumption and obesity);
- Low health literacy;
- Access to quality programs in the community; and,
- Large geography and low population density.

Successes of the past year:

- Implementation of telehomecare programs for people with congestive heart failure and chronic obstructive pulmonary disease serving 550 people. A 20% reduction in ED visits and admissions in the population served is projected.
- Maintenance of the mobile diabetes unit which serves 9 rural communities and over 200 people with diabetes.
- Establishment of the Acute Centre for Diabetes Care at Thunder Bay Regional Health Sciences Centre and Sioux Lookout Meno Ya Win.
- The creation of a lead organization (CCAC) for self-management programs across the North West LHIN and the establishment of a centralized intake for programs. Enhanced uptake to 350 people per year is anticipated.
- Training for 300 health professionals in self-management techniques to build capacity for culture change with ongoing mentoring provided as implementation occurs.
- Establishment of the Regional Coordinating Centre for Diabetes Care through the Northern Diabetes Health Network.
- The creation of two new family health teams and one nurse practitioner led clinic provide enhanced access to primary care.
- An increase in 28 full-time equivalents in nursing positions to support telemedicine consults with specialists.
- The completion of the Health Services Blueprint plan (to 2021) which identifies high impact, high volume chronic disease areas to target

**PART 2: GOALS and ACTION PLANS**

Goal(s)

The goals for CDPM identified in the Integrated Health Services Plan are:

1. Reduce the prevalence of chronic diseases through expansion of primary prevention initiatives.
2. Increase implementation of evidence-based practices in chronic disease management.
3. Enhance self-management amongst clinicians and the people of Northwestern Ontario.
4. Reduce ED visits and avoidable admissions to hospital.
5. Implement the Ontario Diabetes Strategy in the North West LHIN.

Consistency with Government Priorities:

These goals continue to align with key government priorities. In particular, elements of the provincial chronic disease framework are being advanced with the focus on self-management and the implementation of evidence-based practices such as telehomecare. The North West LHIN goals are congruent with those of the Ontario Diabetes Strategy as well.

Action Plans/Interventions

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next three years with concentration on those actions that will be largely implemented within the upcoming year.

| Action Plans<br>"We will deliver the following" | Please indicate the status of project (Not Yet Started, In Progress, Deferred or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column. | | | | | |
|---|---|---|---|---|---|---|
| | 2012/13 | | 2013/14 | | 2014/15 | |
| | Status | % | Status | % | Status | % |
| Established a central access point for self-management programs across the North West LHIN. | Completed | 100% | | | | |
| Transitioned chronic disease self-management programs to an appropriate provider. | Completed | 100% | | | | |
| Increase participation in self-management programs by 20%each year. | In progress | 33% | In progress | 33% | Completed | 34% |
| Support a network of self-management master trainers with funding, networking and ongoing capacity building. | Completed | 100% | | | | |
| Reduce ED visits and acute admissions by 20% for the population served by the CHF and COPD telehomecare programs in the first year of operation. | In progress | 25% | In progress | 25% | In progress | 25% |
| Support the establishment and growth of regional networks to better integrate management of; diabetes, end stage renal disease, stroke and | In progress | 25% | In progress | 25% | In progress | 25% |

| | | | | | | |
|---|---|---|---|---|---|---|
| dementia. | | | | | | |
| Advance Health literacy through partnership with public health units starting with falls prevention in seniors. | In progress | 25% | In progress | 25% | Completed | 50% |
| Implement communities of practice and improve clinical integration for high volume, high impact chronic conditions (i.e. CHF; COPD; Diabetes). | In progress | 25% | In progress | 25% | In progress | 25% |

How will we measure success?

- Readmission rates will decline by 5% for select case mix groupings.
- A 20% reduction in ED visits and acute admissions will be realized in population served by the COPD and CHF telehomecare initiatives after first year.
- A minimum of 350 people will successfully complete self-management programs.
- 90% of self-management program participants will register through the centralized intake at the North West CCAC.

What are the risks/barriers to successful implementation?

- Continued funding through the ODS is essential for self-management programs and the mobile diabetes unit to continue operation.
- The North West LHIN is currently utilizing telehomecare units provided free of charge by the OTN. These units are nearing the end of their life expectancy. The prohibitive cost of telehomecare units may prevent continuation/expansion of the program in the North West LHIN.

What are some of the key enablers that would allow us to achieve our goal?

- Improved access to primary care and specialty care.
- Financial resources to support upgrades to the telehomecare equipment.
- Enhanced telemedicine nursing resources will support improved access.

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

### 2.5 Priority 5: Long-Term Care Services

| PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY |
|---|
| Integrated Health Services Priority: |
| Priority 5: Long-Term Care Services |
| IHSP Priority Description: |
| To create an integrated system of services enabling the people of Northwestern Ontario to live with independence and dignity. |
| Current Status: |

Between 2010 and 2030 the proportion of seniors in the North West LHIN is expected to increase by 85% for those aged 65-74 and by 62% for those aged 75 and over, while the population younger than 65 is expected to decrease by 10% to 23%. The North West LHIN has a greater proportion of seniors who live alone (32.1% vs. 25.7% provincially). Additionally, over 10% of the senior population in the North West LHIN currently has Alzheimer's and related dementia.

The North West LHIN has a number of Long-Term Care services to help maintain seniors in the community in conjunction with the Aging at Home Strategy. Community supports identified to maintain seniors in the home in the North West LHIN include meals on wheels, social and congregate dining, homemaking, home maintenance, transportation and respite. Further, the North West LHIN has identified assisted living services for high-risk seniors as an integral part of the continuum of care.

While access to appropriate services to help maintain seniors in the community continues to be a challenge, recent investments have focused on improving access to supports for seniors through investments in community services, assisted living and long-term care. In 2011, additional capacity was introduced as follows:

- Community Support Services
  - Introduction of new community supports in Red Lake;
  - Expansion of family-directed respite to the Districts of Kenora and Rainy River;
  - Expansion of Red Cross homemaking and home maintenance programs in the City of Thunder Bay;
  - Expansion of respite services in the City of Thunder Bay for older adults with Alzheimers and related dementia;
  - Expansion of the NICE fund in the City of Thunder Bay to provide more flexibility to providers to help maintain seniors in the community in extraordinary circumstances; and,
  - Expansion of CCAC services for low/moderate clients and for high-needs clients.

- Assisted Living Services
  - 20 new units for high-risk seniors in Kenora;
  - 10 new units for high-risk seniors in Rainy River;
  - 5 new units for high-risk seniors in Dryden;
  - 2 new units for individuals with physical disabilities in the City of Thunder Bay;
  - 2 new units for individuals with acquired brain injury in the City of Thunder Bay; and,

- Providers in Nipigon and Atikokan are developing new assisted living services for high-risk seniors that will come into effect in 2012.

Further, The North West LHIN increased its Long-Term Care bed compliment to 1,792 beds with the addition of:

- 22 new permanent long stay beds in Terrace Bay; and,
- 10 new interim beds in Kenora,

Despite these investments, challenges in the North West LHIN in relation to long-term care services include:

- Recruitment and retention of staff continues to be an issue across the continuum of care.
- There is an inability to achieve sufficient critical mass in smaller communities to make it feasible to establish adequate community support services or long-term care space.
- Maintaining LTC homes until such time that new replacement beds are redeveloped is an issue in Thunder Bay.
- Provision of services for residents with behavioural issues in LTC homes.

**PART 2: GOALS and ACTION PLANS**

Goal(s)

1. Increase support available for people and their caregivers.
2. Improve access to appropriate long-term care services.
3. Improve transitions across the continuum of care.
4. Maintain seniors in the community (reducing the need for hospitalization and improving bed utilization, decreasing Alternate Level of Care).
5. Reduce ED visits and avoidable admissions to hospital.

Consistency with Government Priorities:

Long-Term Care Services will be aligned to priority areas identified by the Ministry of Health and Long-Term Care including: additional temporary bed capacity; ER/ALC admission avoidance and timely discharge; enhanced home care; and outreach teams to provide enhanced nursing assessment and treatment services in a home setting. Further, goals reflect the objectives of the Behavioural Supports Ontario Framework and recommendations made by Dr. Walker to improve access to the right care through community investments and to optimize and differentiate capacity in Long-Term Care settings[1].

[1] Dr. Walker, Provincial ALC Lead, "Caring For Our Aging Population and Addressing Alternate Level of Care: Report Submitted to the Minister of Health and Long Term Care", June 30, 2011.

Action Plans/Interventions

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next three years with concentration on those actions that will be largely implemented within the upcoming year.

| Action Plans<br>"We will deliver the following" | Please indicate the status of project (Not Yet Started, In Progress, Deferred or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column. | | | | | |
|---|---|---|---|---|---|---|
| | 2012/13 | | 2013/14 | | 2014/15 | |
| | Status | % | Status | % | Status | % |
| Develop the Centre of Excellence for Integrated Seniors' Services (CEISS) in the City of Thunder Bay. | In progress | 25% | In progress | 25% | Completed | 50% |
| Increased community support services. | In progress | 25% | In progress | 25% | In progress | 25% |
| Enhanced Supportive Housing. | Completed | 100% | | | | |
| Specialty services for clients with responsive behaviours. | In progress | 25% | In progress | 25% | In progress | 50% |
| Develop and implement Regional Behavioural Health Service aligned to Behavioural Supports Ontario Framework. | In progress | 50% | In progress | 25% | In progress | 25% |
| Implement ongoing quality improvement initiatives (i.e. Falls Prevention, Resident First, Advancing Quality within Ontario Long-Term Care, transitions across the continuum). | In progress | 50% | In progress | 25% | In progress | 25% |
| Increase capacity of assisted living services and community supports. | In progress | 33% | In progress | 33% | In progress | 33% |
| Implement Nurse Led Outreach in all Long-Term Care Homes throughout City of Thunder Bay. | Completed | 100% | | | | |
| | | | | | | |

How will we measure success?

- Reduced transfers to the Emergency Department and reduced ALC for individuals with responsive behaviours.
- Reduced transfers to the Emergency Department for Long-Term Care residents.
- Reduction in wait list for initial placement to Long-Term Care.
- Appropriate placement to Long-Term Care (i.e. % of placements with MAPLe scores High or Very High).
- Reduced number of ALC days.
- Increased volume of assisted living and community support services for high risk seniors.

| What are the risks/barriers to successful implementation? |
|---|
| ▪ Health human resources remain a challenge in the North West LHIN, specifically in the Community and Long-Term Care sector.<br>▪ Economies of scale and geographic distances in small rural communities pose a challenge, but offer an opportunity to develop innovative approaches to new service delivery models.<br>▪ OTN capacity to expand may be limited. |
| What are some of the key enablers that would allow us to achieve our goal? |
| ▪ Governance and accountability structures to support system transformation.<br>▪ Health Professional and Public Education and Awareness.<br>▪ Process and Patient Flow Efficiency tracking. |
| Additional Comments (i.e. additional information that supports the implementation/success of the goal) |
| |

### 2.6 Priority 6: Mental Health and Addictions Services

| PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY |
|---|
| Integrated Health Services Priority: |
| Priority 6: Mental Health and Addictions Services |
| IHSP Priority Description: |
| To improve the quality of life for those affected by mental health and addictions issues. |
| Current Status: |
| Thirty-seven community mental health and addictions agencies provide care through funding from the North West LHIN. A number of other services are provided through alternate funding arrangements (i.e. Health Canada. Ministry of Child and Youth Services). There are two Schedule 1 facilities, one in Kenora and one in Thunder Bay and one forensic mental health unit at Thunder Bay Regional Health Sciences Centre.<br><br>Challenges with timely access to mental health and addictions services have been identified for clients requiring crisis services or specialized care. Most residents living outside of Thunder Bay and Kenora rely on telephone access or videoconference linkages to access crisis or psychiatric care. Long wait times and limited services can contribute to exacerbation of existing conditions. Clients continue to identify a lack of coordinated care across and between agencies.<br><br>In addition, there is an increasing demand for access to mental health and addictions services from the First Nation communities in Northwestern Ontario where opiate addiction; high suicide rates; and other substance misuse exists. |

The North West LHIN provides funding for integrated Mental Health and Addictions programs such as the GAPPS (Getting Appropriate Personal and Professional Supports) program. This program responds to the unmet needs of vulnerable persons living with serious, unstable and complex mental illness and addictions issues. The program has been highly successful in providing outreach services; support and system navigation and clinical support services to this population. The program focuses on case in non-traditional settings such as shelters, food banks, soup kitchens, streets and a withdrawal management centre.

The North West LHIN has enhanced community outreach capacity and service coordination for residents with an acquired brain injury and more recently funded additional community capacity for two long-stay alternate level of care patients that waited > 550 days in hospital.

Psychiatric sessional fees were enhanced in the Kenora/Rainy River Districts and the City of Thunder Bay and the District of Thunder Bay.

A detailed analysis of reasons for Mental Health and Addictions visits to the emergency department is underway at Thunder Bay Regional Health Sciences Centre. The goal is to determine the root causes for the visit are prior to determining system solutions. Outside of Thunder Bay, in the Kenora and Rainy River District, health service providers have been exploring integration of mental health and addiction services as a means to improving the coordination of care across the western part of our region. Further funding enhancements have been made to North Superior Programs for mental health and addiction services to the east of Thunder Bay.

The North West LHIN is involved with Community Care Information Management (CCIM) in expanding implementation of the Ontario Common Assessment of Need for Mental Health and Addictions with a goal to complete this work early in 2012-13.

The North West LHIN has developed a Behavioural Support Services System Action Plan that will move forward early in 2012-13.

## PART 2: GOALS and ACTION PLANS

Goal(s)

1. Improve access to mental health and addictions services and make the system easier to navigate.
2. Improve coordination of mental health and addictions services.
3. Improve outcomes for people receiving mental health and addictions services.
4. Implement the provincial 10-year Mental Health and Addictions Strategy.
5. Reduce emergency department visits and avoidable admissions to hospital.

Consistency with Government Priorities:

The North West LHIN's action plans are consistent with the government's goal to improve access to quality family health care and reduce wait times, with a focus on emergency departments. North West LHIN initiatives will support Ontario's Excellent Care for All Act by focusing on quality, value and evidence-based care.

Action Plans/Interventions

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next three years with concentration on those actions that will be largely implemented within the upcoming year.

| Action Plans<br>"We will deliver the following" | Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column. | | | | | |
|---|---|---|---|---|---|---|
| | 2012/13 | | 2013/14 | | 2014/15 | |
| | Status | % | Status | % | Status | % |
| Improve access to community-based mental health and addictions services. GAPPS program clients' average emergency department visits will be reduced from over 10 to less than 4 visits per year. | In progress | 30% | Completed | 70% | | |
| Improve access to specialized mental health services by establishing specially designated bed capacity at the Centre of Excellence for Integrated Senior Services for long-term care home residents from across the North West LHIN who exhibit responsive behaviours. | In progress | 50% | In progress | 25% | Completed | 25% |
| Identify opportunities for partnerships, integration and realignment of mental health and addiction services with a focus on improving access to Schedule 1 facilities. | In progress | 33% | In progress | 33% | In progress | 33% |
| Increase supportive housing for people with substance use issues or concurrent disorders. | In progress | 67% | Completed | 33% | | |
| Implement initiatives aimed at achieving the goals of the provincial 10-Year Mental Health and Addictions Strategy with a focus on Child and Youth. | In progress | 40% | In progress | 30% | In progress | 20% |
| Support and engage with the Mental Health & Addictions (MH&A) Service Collaborative. | TBD | 25% | Completed | 75% | | |

| How will we measure success? |
|---|
| ▪ Reduce unplanned emergency department visits within 30 days of discharge for mental health conditions to achieve LHIN target.<br>▪ Reduce unplanned emergency department visits within 30 days of discharge for substance abuse conditions to achieve LHIN target.<br>▪ Establish specially designated behavioral health program beds at the CEISS as part of the behavioral health support services model.<br>▪ Integration and realignment of mental health and addictions programs/services.<br>▪ Forty-eight supportive housing units will be in place for people with problematic substance use issues or concurrent disorders. |
| What are the risks/barriers to successful implementation? |
| ▪ Tracking of ED visits rates attributable to mental health and addictions demonstrates inconsistent coding practice.<br>▪ Primary reason for visit/admission obscures MH&A causal relationship making it difficult to draw a cause and effect relationship between specific program and ED visit.<br>▪ Voluntary integration opportunities are not readily identified by HSPs. |
| What are some of the key enablers that would allow us to achieve our goal? |
| ▪ Involvement in the mental health and addictions service collaborative.<br>▪ Focused integration action plan for MH&A including alignment of Schedule 1 Facility services.<br>▪ Continued collaboration with system partners. |
| Additional Comments (i.e. additional information that supports the implementation/success of the goal) |
| |

### 2.7 Priority 7: Aboriginal Health Services

| PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY |
|---|
| Integrated Health Services Priority: |
| Priority 7: Aboriginal Health Services |
| IHSP Priority Description: |
| Work collaboratively with the Aboriginal community and the Federal and Provincial Governments in addressing issues of access to culturally sensitive and culturally appropriate health care programs and services. |
| Current Status: |
| The North West LHIN is responsible for overseeing 97 health service providers. There are 44 Aboriginal health services providers who receive funding for community support services, mental health and addiction services and diabetes education. The Aboriginal population in Northwestern Ontario is approximately 44,450, of which, approximately 1/3 are living on reserve. |

Priorities for change include:

- To improve access to and integration of services in the following areas:
  - Community Support Services;
  - Mental Health and Addiction Services; and,
  - Chronic Disease Prevention and Management.

The Aboriginal health issues identified through community engagement continue to focus on chronic diseases such as diabetes, high blood pressure, cardiovascular disease, mental health and addictions issues (opiate epidemic, high suicide rates, alcohol misuse, depression, post-traumatic stress disorders, family violence, schizophrenia and other unique issues such as FASD, teen pregnancy). Program and service limitations continue to be identified as lack of timely access to services, long wait lists, lack of continuity of care, lack of culturally appropriate services and increasing demand for long-term care services within First Nation communities across Northwestern Ontario.

The North West LHIN continues to foster a number of formal and informal health partnerships/relationships between mainstream and Aboriginal communities. Health care technology such as telemedicine and videoconference capabilities help address access issues and reduce barriers for the Aboriginal population living on reserve in remote, rural and northern communities (i.e. tele-rehab and tele-psychiatry).

Key issues facing the Aboriginal population include:

- Limited health care capacity and insufficient infrastructure;
- Lack of consistent funding for health care programs;
- Shortage of physicians and other health human resources;
- Lack of trust that confidentiality issues will be protected by health care providers;
- Lack of program awareness and understanding;
- Lack of full-time mental health and addictions counsellors in the communities to address substance and addictions issues;
- Lack of early recognition and intervention in childhood related to mental health challenges;
- Poor social determinants of health - limited employment opportunities, access to appropriate education, substandard living conditions;
- Lack of integrated approaches to care delivery between jurisdictions;
- Ability to access culturally appropriate programs and services;
- Challenges with language and literacy;
- Lack of after care and follow-up;
- Lack of transportation services; and,
- Continued need to HHR training and education.

Successes of the past year:

The North West LHIN hosted a session in Sioux Lookout in May 2011 bringing together all LHIN CEOs and Aboriginal Leads to discuss the varying needs of the Aboriginal population; gain a better understanding of culturally appropriate care and traditional values; and to collectively work together on a common approach to improving access and integration of care and services to the Aboriginal communities. The group participated in a site visit to two remote northern fly-in communities.

The North West LHIN was actively engaged by the Emergency Services Branch to help facilitate

access to needed health care services during the fire evacuation of several First Nation communities in the summer of 2011. Over 3,000 residents in remote northern fly-in First Nation communities were evacuated.

Since the release of the Coroner's Report on the Pikangikum Community in the North West LHIN, work is underway to explore ways of working together with the various partners across sectors and jurisdictions to help address the mental health and addictions needs of the Aboriginal population. As part of this work, the North West LHIN hosted a Mental Health and Addictions forum in November 2011 bringing together the Aboriginal Health Directors and mainstream Mental Health and Addictions organizations to dialogue about ways to work better together to improve access to MH&A care. A report on the proceedings is forthcoming and will help shape the Mental Health and Addictions strategy for the North West LHIN.

Funding support will be provided to one organization and their key partners to help improve data collection for 14 First Nation communities through a client registry; funding support for a virtual rehabilitation program offered via videoconferencing will improve access to this much needed service in remote First Nation communities; and, the North West LHIN provided funding to support mental health and addiction counselling services in 6 communities.

The North West LHIN has shared the Ontario Common Assessment of Need tool developed by CCIM for the Aboriginal population with the Aboriginal Health Directors and the Aboriginal Advisory Committee. Once the tool is fully validated at a provincial level, there may be an opportunity to use this tool more broadly across the North West LHIN.

The North West LHIN has completed a detailed review of the utilization of health care services (hospital-based services) that reflect individuals on reserve. Reasons for visits to the emergency department or reasons for hospitalization have been identified as part of the Health Services Blueprint. Preliminary results show a high ED visit rate for injury and poisoning.

The North West LHIN has continued to build community capacity and provide assistance to Aboriginal Health Service Providers (HSPs) with the completion of reporting requirements.

There are ongoing efforts to meet with Aboriginal Health Services Providers, Chiefs of First Nation communities and attend and participate in planned events. North West LHIN staff members participate on the Communities in Action initiative and on the Health Services Integration Fund Advisory Committee.

## PART 2: GOALS and ACTION PLANS

Goal(s)

1. Establish mutually respectful relationships with the Aboriginal community.
2. Improve the delivery of services for Aboriginal peoples across the continuum of care.
3. Enable the Aboriginal community to have greater input into health planning that affects their communities.
4. Improve the cultural and linguistic accessibility of local and regional health services.
5. Support the Aboriginal community to effectively manage and report LHIN-funded programs and services.

Consistency with Government Priorities:

The goals listed above support the MOHLTC priorities of improving access to services and integration of services within and across Aboriginal communities in Ontario.

Action Plans/Interventions

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next three years with concentration on those actions that will be largely implemented within the upcoming year.

| Action Plans<br>"We will deliver the following" | Please indicate the status of project (Not Yet Started, In Progress, Deferred or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column. | | | | | |
|---|---|---|---|---|---|---|
| | 2012/13 | | 2013/14 | | 2014/15 | |
| | Status | % | Status | % | Status | % |
| Improve access to culturally sensitive and culturally appropriate health care programs and services, and access to care. | In progress | 30% | In progress | 30% | In progress | 30% |
| Develop an Aboriginal Mental Health and Addictions Strategy to improve health outcomes and improve access to:<br>▪ Community-based mental health and addictions services;<br>▪ Specialized mental health and addictions services; and,<br>▪ Children and Youth services. | Completed | 100% | | | | |
| Implement the strategies outlined in the Community Engagement Strategy. | Completed | 100% | | | | |
| Advance the work of the Aboriginal Health Services Advisory Committee. | Ongoing | | Ongoing | | Ongoing | |
| Leverage information sources in collaboration with other Government departments and Aboriginal health service providers to better inform planning priorities. | In progress | 33% | In progress | 33% | Completed | 34% |
| Actively engage and involve Aboriginal communities and health service providers in local and provincial strategic planning processes. | In progress | 33% | In progress | 33% | Completed | 34% |
| Build capacity in the Aboriginal community for program/services | Ongoing | | Ongoing | | Ongoing | |

| | | | | | | |
|---|---|---|---|---|---|---|
| management and reporting. | | | | | | |
| Implement and evaluate the indicator related to “care experience” with all Health Service Providers (HSPs). | Completed | 100% | | | | |

How will we measure success?

- Improve access and integration of services between Aboriginal communities and mainstream health service providers.
- Create a mental health and addictions strategy for Northwestern Ontario.
- Improve access through use of eHealth technology (telemedicine, videoconference, client registry, where appropriate).
- Implement a culturally appropriate diversity indicator for inclusion in the SAA that demonstrates improvement in the "care experience".

What are the risks/barriers to successful implementation?

- Jurisdictional issues continue to be challenging and opportunities for integration need to be further explored
- Coordination and delivery of health care programs and services is critical as the demand for these services increase and outmigration to larger communities occurs.
- Current models of health care delivery (i.e. mental health and addictions services need to be better integrated).
- Poor health status and social determinants of health exist for this particularly vulnerable population.

What are some of the key enablers that would allow us to achieve our goal?

- Opportunity to expand partnerships with broader sectors and Aboriginal communities to improve access to care and integration of services.
- Continue to build positive relationships with Aboriginal communities though governance to governance sessions and operational planning efforts.

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

### 2.8 Priority 8: Ensuring French Language Services

| PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY |
|---|
| Integrated Health Services Priority: |
| Priority 8: Ensuring French Language Health Services |
| IHSP Priority Description: |
| To ensure that LHIN planning considers the provision of French language health services to improve access to health services for the Francophone population. |
| Current Status: |
| ▪ The North West LHIN is making significant progress in its priority of improving the integration of French Language Services within the local health care system.<br>▪ In its role as system planner and manager of the local health system, the North West LHIN has requested a French Language Services Implementation Plan from the 17 health service providers identified to plan for the provision of services in French. In order to help ensure and monitor continuous improvement in the quality, accessibility and integration of FLS with Health Service Provider operations, planning for FLS will be monitored through a progress report submitted by providers by April 30th for the years 2011-12, 2012-13 and 2013-14.<br>▪ Internal processes have been developed to include a French section on the LHIN website and education sessions for staff have been held to increase knowledge and awareness of FLS.<br>▪ The North West LHIN has a signed accountability agreement with the Réseau du mieux-être francophone du Nord de l'Ontario as the French Language Health Planning Entity for the North West and North East LHINs.<br>▪ A joint LHIN liaison committee has been created between the North East, the North West LHIN, and the Entity.<br>▪ A joint LHIN/Entity work plan has been developed for 2011-2012. |
| **PART 2: GOALS and ACTION PLANS** |
| Goal(s) |
| 1. Support initiatives designed to attract and retain French speaking service providers.<br>2. Integrate French language health services in LHIN planning activities. |
| Consistency with Government Priorities: |
| This goal supports the government's vision of a healthier Ontario and the Ministry of Health and Long-Term Care's priorities of:<br>▪ Improve the care experience and quality of care through access to health care services in French.<br>▪ Reduce unnecessary ED visits and reduce the time patients spend waiting in the Emergency |

Department for care.

Action Plans/Interventions

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next three years with concentration on those actions that will be largely implemented within the upcoming year.

| Action Plans<br>"We will deliver the following" | Please indicate the status of project (Not Yet Started, In Progress, Deferred or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column. | | | | | |
|---|---|---|---|---|---|---|
| | 2012/13 | | 2013/14 | | 2014/15 | |
| | Status | % | Status | % | Status | % |
| Engage with the Francophone community to identify local health needs and priorities. | Ongoing | | Ongoing | | Ongoing | |
| Promote awareness and sensitivity to French language health service issues with providers. | Ongoing | | Ongoing | | Ongoing | |
| Monitor on a yearly basis progress of FLS Implementation plans. | Ongoing | | Ongoing | | Ongoing | |

How will we measure success?

- Will have access to more reliable data on health needs and health planning priorities of the Francophone community in the North West LHIN through the work of the Entity.
- Will have a current understanding of FLS resources to support the provision of FLS.
- Increased responsiveness of providers to the health needs of the Francophone population.
- Improved care experience for the Francophone population as evidenced by the ability to access FLS services.
- Increased integration of FLS into day-to-day business of providers.
- Increased awareness of available services in French by Francophone population.

What are the risks/barriers to successful implementation?

- Lack of French-speaking health professionals in the North West LHIN.
- Rigidity of rules not allowing for providers to be flexible in sharing FLS resources.
- Competing priorities creates challenges for HSPs to adequately address FLS.

What are some of the key enablers that would allow us to achieve our goal?

- Health service providers could work together to collaborate on strategies to provide FLS services to the French-speaking population in the North West LHIN.
- HSPs can engage the French Language Health Planning Entity to provide information on health needs of the Francophone community.

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

### 2.9 Priority 9: Health Human Resources

| PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY |
|---|
| Integrated Health Services Priority: |
| Priority 9: Health Human Resources |
| IHSP Priority Description: |
| To maximize use of current health human resources and plan for future needs. |
| Current Status: |
| ▪ Outmigration of youth and mid-age adults poses challenges to the development of a solid HHR plan.<br>▪ Recruitment and retention of health service providers continues to be an issue in the North West LHIN.<br>▪ The majority of post-secondary and continuing education is provided through Confederation College, Lakehead University and the Northern Ontario School of Medicine.<br>▪ Interprofessional education and care is a growing focus for each academic institution. An anticipated outcome of interprofessional education is the maximized use of available health human resources and improved care provision and patient satisfaction.<br>▪ As part of the Health Services Blueprint currently under development, HHR needs will be reviewed and the final report will contain recommendations for a 10-year HHR plan.<br><br>Successes in the past year:<br>▪ Working with local hospitals, HealthForceOntario (HFO) and the regional locum pilot project; potential ED closures due to lack of physician coverage were averted.<br>▪ Community Partnership Program Coordinator hired by HFO to advance physician recruitment and planning has supported ED locum recruitment efforts. New models of care are in place (i.e. nurse practitioner clinic, nurse-led outreach team for long-term care and additional family health teams). There are opportunities for employment and interprofessional practice.<br>▪ North West LHIN and North East LHINs have membership on the Northern Interprofessional Collaboration for Health Education (NICHE) committee.<br>▪ 28 full-time equivalent nurses were hired to support telemedicine visits. |
| **PART 2: GOALS and ACTION PLANS** |
| Goal(s) |
| 1. Develop an understanding of current health human resource (HHR) requirements across the North West LHIN and in each sub-area.<br>2. Spread the work of HealthForceOntario.<br>3. Foster expanded implementation of interprofessional practice models, utilizing clinicians to their full scope.<br>4. Influence change leading to improved efficiency and effectiveness of clinical practice. |

Consistency with Government Priorities:

The North West LHIN goals and action plans are consistent with and support the government goal to ensure Ontarians have access to the right number and mix of qualified health care providers.

Action Plans/Interventions

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next three years with concentration on those actions that will be largely implemented within the upcoming year.

| Action Plans<br>"We will deliver the following" | Please indicate the status of project (Not Yet Started, In Progress, Deferred or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column. | | | | | |
|---|---|---|---|---|---|---|
| | 2012/13 | | 2013/14 | | 2014/15 | |
| | Status | % | Status | % | Status | % |
| Identify HHR challenges and opportunities for new models of care delivery and work with health service providers in planning for future HHR needs. | In progress | 33% | In progress | 33% | Completed | 34% |
| Support interprofessional learning and practice.<br>▪ Support Northern Interprofessional Collaboration for Health Education (NICHE) initiatives.<br>▪ Encourage health service providers to participate in opportunities related to interprofessional care and education.<br>▪ Celebrate local successes. | In progress | 33% | In progress | 33% | Completed | 34% |
| Link with academic health science partners to identify and address gaps, opportunities, skills and educational issues related to the evolving interprofessional model of care. | In progress | 33% | In progress | 33% | Completed | 34% |
| Support and expand access to health service providers, particularly in northern and remote communities through increased use of telemedicine. | In progress | 33% | In progress | 33% | Completed | 34% |

How will we measure success?

- Increased numbers of clients seen by interprofessional teams.
- Decreased wait times for appointment with care providers.
- Decreased number of unattached patients.
- Integration between interprofessional care and education and practice environments.

| |
|---|
| ▪ Increase in interprofessional care teams across health care settings. |
| What are the risks/barriers to successful implementation? |
| ▪ Continued outmigration of the younger population leaves limited room to grow HHR capacity organically.<br>▪ Ongoing challenges with recruitment and retention of health care providers.<br>▪ Lack of ongoing financial support for interprofessional care/education initiatives.<br>▪ Inadequate supply of family physicians, especially in Thunder Bay. |
| What are some of the key enablers that would allow us to achieve our goal? |
| • Ongoing support for interprofessional care models, training and demonstration projects.<br>• Maintaining and expanding programs that support recruitment and retention of health care professionals in northern and rural communities.<br>• Expansion of eHealth initiatives to improve access to care. |
| Additional Comments (i.e. additional information that supports the implementation/success of the goal) |
| |

### 2.10 Priority 10: eHealth

| PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY |
|---|
| Integrated Health Services Priority: |
| Priority 10: eHealth |
| IHSP Priority Description: |
| eHealth is about using information and communication technology to modernize the health system and to provide better and safer patient care. It is about healthier people, better health decisions and productivity and better administrative and system-wide resource allocation. |
| Current Status: |
| ▪ A comprehensive Northern Ontario Information and Communication Technology (ICT) Blueprint 2007-2012 provides vision and strategic direction for the eHealth program in the North West LHIN.<br>▪ A comprehensive Northern Ontario ICT Tactical Plan 2007-2012 which identifies specific eHealth projects and implementation plans for the eHealth program in the North West LHIN is being executed.<br>▪ A comprehensive North West LHIN eHealth Implementation and Adoption Preparedness Tactical Plan is being executed. The focus is on building readiness to implement and adopt the provincial Chronic Disease Management System (CDMS) – Diabetes eHealth solution. Approximately 30% of the work associated with this tactical plan has been completed.<br>▪ The North West LHIN blueprint and tactical plans align with the eHealth Ontario 2009-2012 Provincial Strategy.<br>▪ eHealth projects in progress in the North West LHIN include: Northern Ontario Information and Communication Technology (ICT) Blueprint Refresh; Hospital Information System (HIS) consolidation; CDMS- Diabetes; Connecting North and Eastern Ontario (cNEO) Cluster Planning; Provincial Resource Matching & Referral (RM&R) Planning and Standardization, eReferral and Resource Matching Pilot; ePhysician – Physician Office Integration Expansion; |

ePhysician – eCredentialing; Ontario Common Assessment of Need (OCAN) and related Integrated Assessment Record (IAR); Ontario Lab Information System (OLIS) Planning; Northern and Eastern Ontario Diagnostic Imaging Network (NEODIN) Picture Archiving and Communication System (PACS); First Nation Community Client Registry Demonstration Project; and the Community Care Information Management Integrated Data Initiative.

- 12 of 13 hospitals in the North West LHIN share the Meditech Hospital Information System (HIS).
- 23 sites in the North West LHIN share a regional Picture Archiving and Communication System (PACS).
- Approximately 61% of all family practice physicians in the North West LHIN utilize an electronic clinical management system (CMS).
- There are 137 Ontario Telemedicine Network (OTN) member sites in the North West LHIN. In 2010/11 there were close to 20,000 clinical telemedicine events.
- The Kuhkenah Network (K-Net) provides information and communication technologies (ICTs), telecommunication infrastructure and application support in First Nation communities across a vast, remote region of Northwestern Ontario as well as in other remote regions in Canada. K-Net is a program of Keewaytinook Okimakanak (KO) a First Nation Tribal Council that serves 26 First Nation Communities through KO Telemedicine (KOTM).
- Key eHealth issues facing the North West LHIN include operational sustainability of eHealth projects; eHealth human resource/know-how; readiness amongst health service providers; and network connectivity in remote communities.

Successes in 2011-2012 include:

- Collaborating with 3 other LHINs to initiate the Connecting North and Eastern Ontario cluster project to advance the planning and implementation of the eHealth Ontario 2015 Blueprint architecture.
- Implementation of the Integrated Assessment Record/Doorways Portal project.
- Increased implementation and adoption readiness amongst Health service providers throughout the LHIN

## PART 2: GOALS and ACTION PLANS

Goal(s)

1. Increase eHealth ICT project implementation and adoption capability throughout the North West region.
2. Improve the value, timeliness and amount of decision support for health system decision makers.
3. Increase the accessibility of high quality eHealth ICT solutions to health service providers.
4. Increase the understanding of eHealth ICT amongst the general public.
5. Improve patients' access to their health information and to health care management tools to support self-care.

Consistency with Government Priorities:

These goals are aligned with advancing the government's key eHealth Clinical Priorities of: Diabetes Management, Medication Management and Wait Times Management. These goals also support the government's key eHealth Foundational Priorities of building Cornerstone Information Systems, Clinical Activity Information Systems, Technology Services and Enabling Practices and Talent Management.

Action Plans/Interventions

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next three years with concentration on those actions that will be largely implemented within the upcoming year.

| Action Plans<br>"We will deliver the following" | Please indicate the status of project (Not Yet Started, In Progress, Deferred or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column. | | | | | |
|---|---|---|---|---|---|---|
| | 2012/13 | | 2013/14 | | 2014/15 | |
| | Status | % | Status | % | Status | % |
| Implement the North West LHIN, CDMS-Diabetes Implementation and Adoption Readiness Tactical Plan. | In progress | 40% | In progress | 15% | In progress | 15% |
| Expand and evolve the eHealth Project Management Office in the North West LHIN. | In progress | 10% | In progress | 10% | - | |
| Develop expert clinical panels to guide eHealth ICT efforts. | Completed | 100% | | | | |
| Increase the frequency of engagement on the value and use of eHealth with health service providers and the general public. | In progress | 35% | In progress | 25% | In progress | 25% |
| Implement the CDMS-Diabetes (**dependent on eHealth Ontario plan). | In progress | 50% | Completed | | | |
| Accelerate the integration of Electronic Medical Records (EMR) amongst individual Health Service Provider organizations. | In progress | 50% | In progress | 10% | In progress | 10% |
| Expand eHealth ICT infrastructure and support required to create a regional electronic health record (EHR). | In progress | 60% | In progress | 15% | In progress | 15% |
| Increase access to and expansion of telemedicine services. | In progress | 50% | In progress | 25% | In progress | 10% |
| Establish a comprehensive, clinical web portal for health service providers throughout the North West LHIN. | In progress | 15% | In progress | 25% | In progress | 25% |
| Develop and implement an electronic referral and resource matching solution per the provincial reference model. | Completed | 100% | | | | |
| Implement eHealth technologies to support consumers to achieve | In progress | 20% | In progress | 20% | In progress | 20% |

| | | | | | | |
|---|---|---|---|---|---|---|
| improved health outcomes. | | | | | | |
| Implement the Ontario Laboratory Information System (OLIS) with hospitals' HIS. | In progress | 20% | Completed | | | |
| Accelerate the deployment of eHealth Ontario's secure ONE Mail service to Healthcare Service Providers. | In progress | 10% | In progress | 10% | In progress | 10% |
| Facilitate community engagement, implementation and readiness services and subject matter expertise to support the Connecting Northern & Eastern Ontario (cNEO) project. | In progress | 33% | In progress | 33% | Completed | 34% |

How will we measure success?

- Increase the # of weighted units of the NW LHIN interoperable electronic health record (iEHR) that advances/aligns with the overall provincial iEHR architecture
- Increase the # of Health Service Provider (HSP) electronic medical record (EMR) integration points with regional or provincial interoperable electronic health record (iEHR)
- Increase the # of clinicians using eHealth (ICT ) that advances/aligns with the overall provincial eHealth strategy
- Ensure 100% of eHealth Ontario Deliverables are completed successfully on project initiatives
- Continue to advance the North West LHIN eHealth technical "getting ready" plan

What are the risks/barriers to successful implementation?

- Limited buy-in and commitment from stakeholders results in slower implementation and adoption of eHealth initiatives than contemplated.
- Insufficient human resource capacity and political will amongst HSPs to implement and adopt numerous new eHealth solutions on an aggressive timeline.
- Financial resource capacity in the LHIN to operationally sustain the numerous new eHealth solutions being rolled out provincially.
- Further delays or additional uncertainty at eHealth Ontario result in loss of confidence in the eHealth strategy by providers or pull back from implementation and adoption of eHealth initiatives.
- Legal or regulatory changes lengthen presently contemplated implementation plans.

What are some of the key enablers that would allow us to achieve our goal?

- A sustained funding level for services is critical to the achievement of our goals. With sustained operating funding, hospitals and health service providers will be able to continue to offer services in the interim while undertaking the transformational activities noted above that are required for long-term sustainability.

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

### 2.11 Priority 11: Integration of Services Along the Continuum of Care

| PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY |
|---|
| Integrated Health Services Priority: |
| Priority 11: Integration of Services Along the Continuum of Care |
| IHSP Priority Description: |
| To facilitate and enable integration of services across the health care continuum that optimizes health outcomes and improves system performance. |
| Current Status: |

The large landmass and relatively small, dispersed population of the North West LHIN results in challenges for health service delivery, including access to care, health human resources, transportation, the need for extensive travel and higher costs of care per capita.

Access to services along the continuum of care in many communities across the North West LHIN is a challenge. This is evidenced by the larger proportion of unattached patients, high use of emergency department and hospital services, the Alternate Level of Care pressures, and data obtained through community engagement

The North West LHIN has some important strengths:

- The North West LHIN is a leader in the use of technology to improve access to care;
- Health service providers have a history of working together to meet the needs of their clients; and,
- The North West LHIN is recognized for its innovation related to service provision and health human resource planning and training.

Higher proportions of Alternate Level of Care patients in hospital, an aging population, a shortage of HHR and a slowing economy contribute to the need for more integration to improve service delivery and patient satisfaction. The full benefits of vertical, horizontal and cross-sectoral integration have yet to be realized. The focus of care needs to move from provider and silo-based care to patient-centered care.

Over the past year, the North West LHIN embarked on the development of a Health Services Blueprint out to 2021 (a plan) that focuses on integration of care across the continuum and sustainability of the health care system in Northwestern Ontario. The Blueprint recommendations and final report is due at the end of March 2012. Preliminary findings indicate that there is a need to transform the system from a reactive model to a proactively managed system of care.

Several clinical integration activities have been undertaken in the North West LHIN. Implementation of the "Home First" philosophy in Thunder Bay and Kenora (two of our high-pressure alternate level of care sites) have embraced this significant culture and clinical practice change. The initiative has improved joint discharge planning efforts across the continuum.

Greater standardization and integration of clinical practice will support improvements in quality of care

for Congestive Heart Failure clients who are at high risk of "readmission to hospital". To date, the pilot demonstrates a 33% decrease in readmission rates to hospital for this target population.

The North West LHIN has worked in partnership with the North West Community Care Access Centre to support expansion of their role in assessment, eligibility and placement for adult day centres and supportive housing services across our region.

eHealth initiatives that support integration are underway. For example:

- an eICU telehealth outreach service to emergency departments across our region is in development;
- an eCredentialing project will improve and facilitate timely credentialing of physicians across hospitals in our region; and,
- use of the common "order sets" for admission to hospital will help standardize the approach to admission by physicians and provide greater continuity in care.

The higher proportion of Alternate Level of Care, an aging population, higher proportion of Aboriginal population living on reserve in remote northern fly-in only communities; a shortage of HHR and a slowing economy contribute to the need for a fully integrated care delivery model.

**PART 2: GOALS and ACTION PLANS**

Goal(s)

1. Promote a culture of collaboration and accountability between health service providers for health system performance and outcomes.
2. Implement and support integration activities that add value to the health system.
3. Increase and coordinate the utilization of technology that supports integration.
4. Improve client satisfaction with their care experience.
5. Reduce emergency department visits and avoidable admissions to hospital.

Consistency with Government Priorities:

- *Leading Health System Transformation in our Communities: 2010 to 2013 North West LHIN Strategic Directions* and the North West LHIN's IHSP closely align with and support the provincial directions of the Ministry of Health and Long-Term Care (MOHLTC).
- The North West LHIN's action plans are consistent with the government's goals to provide access to an integrated seamless system of care.

Action Plans/Interventions

This section articulates "how you will achieve your goals". Please provide details of action plans/interventions for the specific goals/objectives listed above. Action plans are to include the activities over the next three years with concentration on those actions that will be largely implemented within the upcoming year.

| Action Plans<br>"We will deliver the following" | Please indicate the status of project (Not Yet Started, In Progress, Deferred or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column. | | | | | |
|---|---|---|---|---|---|---|
| | 2012/13 | | 2013/14 | | 2014/15 | |
| | Status | % | Status | % | Status | % |
| Develop a detailed implementation plan for the Health Services Blueprint and begin implementation of the detailed implementation plan. | In progress | 10% | In Progress | 20% | In Progress | 30% |
| Implement integration activities (formal/informal) within and between health care sectors that optimize the patient experience and population health. | Three integration activities planned | | Ongoing | | Ongoing | |
| Implement evidence-based practice and innovative models of care that improve the quality and coordination of care. | Ongoing | | Ongoing | | Ongoing | |
| Implement eHealth solutions to integrate clinical processes between health care sectors where appropriate. | In progress | 33% | In progress | 33% | In progress | 33% |
| Invest in integration opportunities. | Ongoing | | Ongoing | | Ongoing | |
| Profile integration initiatives that support a more seamless patient experience. | Ongoing | | Ongoing | | Ongoing | |
| Include indicators related to integration in accountability agreements. | Ongoing | | Ongoing | | Ongoing | |

How will we measure success?

- Health Services Blueprint implementation plan initiated in 2012-2013.
- Patient Referral and Matching system is aligned with provincial reference model.
- Home First philosophy sustained in practice and influences improved integration of clinical services across the continuum.
- Quality improvement capacity increases and use of leading practice is evident through initiatives.
- Integration initiatives expand across sectors and within communities and districts.
- Integration efforts improve linkages between on-reserve and mainstream health care services.
- eHealth solutions enable effective use of health human resources in our region.
- eHealth solutions enable integration and improve access to services.

| What are the risks/barriers to successful implementation? |
|---|
| ▪ System readiness for the degree of change required with integration of services may be a barrier.<br>▪ Economic challenges exist across communities in the Northwest; integration as a term creates concern about loss of jobs.<br>▪ Political climate may pose challenges to proceeding with planned integration activities.<br>▪ Limited health human resources creates challenges to respond to the continued move to community-based care. |
| What are some of the key enablers that would allow us to achieve our goal? |
| ▪ Focus on client versus provider needs as a shared vision of an integrated network at the community level; district level and programmatically at the regional level.<br>▪ Opportunity of timing and funding to advance integration initiatives. |
| Additional Comments (i.e. additional information that supports the implementation/success of the goal) |
| |

**2.12 Health Services Blueprint**

The North West LHIN embarked on the development of a comprehensive Health Services Blueprint which will inform health planning in our region for the next decade (2021). The comprehensive health services plan will identify integration opportunities at the community, district and regional level within the North West LHIN.

The blueprint is a road map to improve integration and coordination of care; create system efficiencies; identify optimal use of available resources; and create opportunities for sustainability of the health care services over the next ten years as the demand for services increases and resources available to support this increase are challenged.

The final report with recommendations is anticipated by March 31, 2012.

# 3.0 LHIN Staffing and Operations

**LHIN Operations Spending Plan**

| LHIN Operations<br><br>Sub-Category<br>($) | 2011/12 Forecast | 2012/13 Planned Expenses | 2013/14 Planned Expenses | 2014/15 Planned Expenses |
|---|---|---|---|---|
| Salaries and Wages | 2,680,000 | 2,940,000 | 3,015,000 | 3,090,000 |
| **Employee Benefits** | | | | |
| HOOPP | 260,000 | 285,000 | 293,000 | 300,000 |
| Other Benefits | 305,000 | 335,000 | 343,000 | 350,000 |
| Total Employee Benefits | 565,000 | 620,000 | 636,000 | 650,000 |
| **Transportation and Communication** | | | | |
| Staff Travel | 140,000 | 140,000 | 140,000 | 120,000 |
| Governance Travel | 65,000 | 65,000 | 65,000 | 65,000 |
| Communications | 73,000 | 75,000 | 75,000 | 75,000 |
| Total Transportation and Communication | 278,000 | 280,000 | 280,000 | 260,000 |
| **Services** | | | | |
| Accommodation | 255,000 | 270,000 | 275,000 | 280,000 |
| Consulting Fees | 270,000 | 121,192 | 25,192 | - |
| Governance Per Diems | 120,000 | 120,000 | 120,000 | 115,000 |
| LSSO Shared Costs | 544,000 | 360,000 | 360,000 | 360,000 |
| LHIN Collaborative | 50,000 | 50,000 | 50,000 | 50,000 |
| Other Meeting Expenses | 40,000 | 40,000 | 40,000 | 35,000 |
| Other Governance Costs | 50,000 | 50,000 | 50,000 | 41,000 |
| Printing & Translation | 45,000 | 40,000 | 40,000 | 35,000 |
| Staff Development | 65,000 | 65,000 | 65,000 | 50,000 |
| Total Services | 1,439,000 | 1,116,192 | 1,025,192 | 966,000 |
| Supplies and Equipment | 56,192 | 60,000 | 60,000 | 50,000 |
| IT Equipment | 13,000 | 15,000 | 15,000 | 15,000 |
| Total Supplies and Equipment | 69,192 | 75,000 | 75,000 | 65,000 |
| LHIN Operations: Total Planned Expense | 5,031,192 | 5,031,192 | 5,031,192 | 5,031,192 |
| Annual Funding Target | 5,031,192 | 5,031,192 | 5,031,192 | 5,031,192 |
| Variance | 0 | 0 | 0 | 0 |

## LHIN Staffing Plan (Full-Time Equivalents)

| Position Title | 2011/12 Actuals as of Mar. 31/11 FTEs | 2012/13 Forecast FTEs | 2013/14 Forecast FTEs | 2014/15 Forecast FTEs |
|---|---|---|---|---|
| CEO | 1 | 1 | 1 | 1 |
| Senior Directors | 2 | 2 | 2 | 2 |
| Directors | 0 | 2 | 2 | 2 |
| Controller | 1 | 1 | 1 | 1 |
| Sr. Planning/Integration/ Engagement Consultants | 5 | 5 | 5 | 5 |
| Sr. Funding/Performance Consultants | 3 | 3 | 3 | 3 |
| Epidemiologist | 1 | 1 | 1 | 1 |
| Communication Specialists | 1 | 2 | 2 | 2 |
| Funding/Performance Consultants | 1 | 1 | 1 | 1 |
| Planning/Integration/Engagement Consultants | 2 | 3 | 3 | 3 |
| Business Analysts | 2 | 1 | 1 | 1 |
| Executive Assistant | 1 | 1 | 1 | 1 |
| Corporate Coordinator | 1 | 1 | 1 | 1 |
| Accounts Payable/Finance Clerk | 1 | 1 | 1 | 1 |
| HR Assistant | 0 | 1 | 1 | 1 |
| Admin/Program Assistants | 4 | 5 | 5 | 5 |
| Data Analyst | 0 | 1 | 1 | 1 |
| Receptionist | 1 | 1 | 1 | 1 |
| e-Health | 4 | 4 | 4 | 4 |
| FLS Coordinator, Aboriginal planner, ER/ALC Lead, ED LHIN Lead, CC Lead, Primary Lead | 4 | 6 | 6 | 6 |
| Total FTEs | 35 | 43 | 43 | 43 |

# 4.0 Annual Business Plan 2012/13 Communication Plan

***Purpose of Annual Business Plan***

The ABP is one of two guiding documents that are critical to the work of the North West LHIN. The other document is the Integrated Health Services Plan 2010-13 (IHSP).

The IHSP identifies the priorities for change to improve the health system of care in Northwestern Ontario and defines the activities to be undertaken from 2010 to 2013 to advance these priorities.

The ABP demonstrates progress made toward reaching the IHSP goals and objectives and 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.

***Why do we do an ABP?***

Under the Local Health Systems Integration Act (LHSIA) 2006, and the Ministry-LHIN Performance Agreement (MLPA), LHINs are required to publish their Annual Business Plan to inform stakeholders about the LHIN's strategies and initiatives for addressing IHSP priorities. The North West 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 health care providers, consumers and the general public 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 2012-13 fiscal year.

***Target Audiences***

The North West LHIN deals with many stakeholder audiences, each with its own and often differing, understanding of the health care system and the role of the LHIN in funding, planning and integrating the system. Stakeholders can be categorized in several categories and sub-categories:

- Ministry of Health and Long-Term Care
- Internal to the North West LHIN
    - North West LHIN Board of Directors
    - North West LHIN Senior Leadership Team
    - North West LHIN Staff
- North West LHIN Advisory Committee

- North West LHIN Health Integration Leadership Council
- North West LHIN Aboriginal Health Services Advisory Team
- North West LHIN Health Professionals Advisory Council (HPAC)
- North West LHIN Emergency Department/Critical Care Advisory Committee
- Joint Committee for the North West, North East and French Language Services Planning Entity

- Internal to the Health Care System
  - Hospitals
  - North West CCAC
  - Long-term Care Homes
  - Community Health Centres
  - Community Support Service Agencies
  - Mental Health and Addictions Agencies
- External Stakeholders
  - MPPs
  - General Public
  - Media

***Communications Strategy***

The Annual Business Plan describes many key initiatives to advance the priorities of the IHSP and each will have its own communication strategy. In addition, the North West LHIN has an overall strategic communications plan.

This section of the ABP therefore will focus on the strategy to build awareness and understanding of the ABP among all stakeholder groups.

| Stakeholder | Timing | Tactic | Details |
|---|---|---|---|
| **DRAFT ABP** | | | |
| North West LHIN Board of Directors | January 2012 | Board meeting Closed Session | The draft ABP to be presented for approval. |
| Ministry of Health and Long-term Care | January 31, 2012 | Electronic Submission | Submission of draft ABP to MOHLTC once approved by the Board of Directors. |
| **Final ABP** | | | |

| Stakeholder | Timing | Tactic | Details |
|---|---|---|---|
| North West LHIN Board of Directors | May 2012 | Open Board meeting | The final ABP to be presented for approval. |
| North West LHIN Advisory Groups | Upon Ministry approval | Meetings/formal presentations | Summary presentation plus full text of ABP. |
| Hospitals/CCAC/LTCH/CHCs/ Community support service agencies/MH&A agencies MPPs | Upon Ministry approval | Email notification | An email, from the LHIN CEO, including attachment of full text ABP, in advance of public posting. |
| Media/General Public | Upon Ministry approval | Media Release and Posting on LHIN Website | Simultaneous posting by all LHINs of MLPA and ABP. |

**Part 2 – Communication Plan for Specific Initiatives**

While the LHIN system enables health planning to address local issues, there are a number of common initiatives and platforms that can best be addressed in a coordinated and consistent fashion. To support these activities and to enhance the awareness of the LHIN role with key stakeholders, LHINs, with the support of the Ministry of Health and Long-Term Care, have worked together to ensure a consistent overarching communication plan and branding approach to support the following key provincial priorities:

1. **Home First:** Home First is a philosophy and common understanding that when a person enters a hospital with an acute episode, every effort is made to ensure adequate resources are in place to support the person to ultimately go home on discharge, if appropriate.

2. **Senior Friendly Hospitals:** Research shows that seniors are more vulnerable to adverse events and complications the longer they stay in the hospital. They have a two-fold risk of adverse events (i.e. falls, pressure ulcers, surgical complications and hospital-acquired delirium). One-third of frail seniors lose independent function as a result of hospital practices. These risks increase the likelihood that seniors will not be able to be discharged and will become ALC.

   The Senior Friendly Hospital strategy strives to foster hospital environments that respond to seniors' physical and mental health needs, promote good health (i.e. nutrition, activation), are safe (i.e. prevent drug interactions, infections, falls) and involve seniors, their families and caregivers fully in the client's care. After their acute care is completed, seniors regain their health so that they can transition to the next level of care – post-acute, home, community or long-term care.

3. **Provincial Falls Prevention Strategy:** In September 2010, falls prevention was identified as a top priority by the Ministry of Health and Long-Term Care (MOHLTC). In

response, the *Integrated Provincial Falls Prevention Project* was initiated as a Local Health Integration Network (LHIN)-priority project, in partnership with Ontario's Public Health Units.

The *Integrated Provincial Falls Prevention Framework & Toolkit* was developed to improve quality of life for Ontario seniors aged 65 years and over and to lessen the impact of falls on the health care system by reducing the number and impact of falls.

4. **Resource Matching and Referral:** Some of the most significant quality of care issues occur in transition points in the health care system as patients/clients move from one provider to the next. In the absence of an electronic system to support patient referrals, health care providers frequently base referrals on incomplete knowledge of available services and significant time and resources are spent on the administrative burden of completing and faxing multiple forms.

   To address this issue, Ontario's LHINs are working together towards an electronic referral information solution based on a system first introduced in the Toronto Central LHIN. A Resource Matching & Referral (RM&R) system expedites referrals and matches individuals to the earliest available services that best meet their needs, improving quality of care and the experience of individuals and families.

5. **Behavioural Support Services:** In January 2010, the Ministry of Health and Long-Term Care funded a working group to undertake the first phase of an Ontario Behavioural Support System (BSS) Project and develop a principle-based Framework for Care. The framework would enhance services for elderly Ontarians with complex and 'responsive' behaviours wherever they live – at home, in long-term care homes or elsewhere. Responsive behaviours are aggression, wandering, agitation as well as others and for many people, are the trigger for a crisis visit to hospital and transfer to long-term care.

   The reasons identified to undertake this project were:

   - The numbers of people at risk for responsive behaviours is increasing;
   - Challenges are experienced across all health sectors and services;
   - The person and family required better quality experiences;
   - There are significant costs associated with managing behaviours;
   - There are recognized best practices that could be more systematically adopted;
   - There is an opportunity to leverage existing initiatives in Ontario; and,
   - There is a stakeholder readiness for change.

6. **CCAC Expanded Role:** In 2010, a LHIN/CCAC working group was established to define a consistent or common approach to ensure legislative changes to enable an expanded role for the CCAC. This group has defined how the expanded role should be implemented, outlined what needed to be done consistently across the LHINs and what flexibility would be required for local implementation.

The working group concluded that a more global review of the CCACs' role was needed and it was agreed the focus of their work would be on:

- Defining a vision and directional plan for an expanded CCAC role within an integrated system; and,
- Developing a practical framework to support the consistent implementation of the CCACs' expanded role in placement.

In late, 2010, the 14 LHIN and 14 CCAC CEOs agreed upon carrying out the following five ***Directions for Actions***:

1. To ensure the right care at the right place at the right time, the CCACs and LHINs are working in partnership to optimize CCAC capacity:
   i) to be the single point of access for defined health services; and,
   ii) to be a connection for Ontarians to the most appropriate health care services.

2. CCACs will be the single point of access for expanded services for placement (i.e. adult day programs, complex continuing care, rehabilitation and supportive housing/assisted living). Access for placement will incorporate best practices and a standard approach throughout the province. Each LHIN/CCAC will develop an implementation plan for their area by March 31, 2011.

3. CCACs will be the single point of access for assisted living services described in the Assisted Living Services for High Risk Seniors Policy.

4. The practical steps and success factors identified through a survey and interviews with LHINs and CCACs will be used as a common, practical framework and provincial directional plan to implement the expanded role of CCACs. Each LHIN/CCAC will develop more detailed directional plans that will include deliverables, responsibilities and timelines.

5. Each LHIN/CCAC will determine whether to implement the opportunities associated with new prescribed services, new care settings, and use of therapy assistants/aides given that these implementations are highly dependent on local needs and circumstances (i.e. availability of health human resources, financial constraints). The CCACs will share best practices information to build on others' successes.

Communicating the Provincial LHIN Priorities:

The overarching communications plan is a shared responsibility between the 14 LHINs, the MOHLTC and the Minister's Office. The plan speaks to both a shared communication strategy and communication and operational activities to be undertaken by all LHINs, specifically related to a number of LHIN priority projects. It is the platform upon which the LHINs reinforce the LHIN brand and value of the organizations in leading the important transformation of Ontario's health system.

It is to be noted that the progress of programs supporting the provincial LHIN priorities varies among the LHINs. For example, one LHIN may be deeply entrenched in one priority while at the planning stage of another. For this reason, the overarching plan provides a commonality from which each LHIN can then develop a local communication plan for specific initiatives. However, the communications objectives, target audiences and key messages developed in the overarching plan are to be incorporated into every local communications plan.

**Strategic Objectives:**

- To raise the profile and demonstrate the value of LHINs at a provincial level;
- Create a communications campaign that highlights LHIN initiatives and promotes the value LHINs across Ontarians; and,
- Campaign is focused on “Access to Care”.

**Audiences (in order of importance):**

- Public (Taxpayers, patients/clients and family members);
- Health Service Providers (funded and non-funded such as public health);
- Health Service Provider Governance representatives;
- Physicians (specialists & general practitioners);
- North West LHIN Advisory Groups;
- Local government stakeholders (municipal & provincial);
- Premier;
- Minister of HLTC;
- Minister’s Office;
- Ministry of Health and Long-Term Care; and,
- Media.

**Communication Boilerplate:**

*LHINs bring together health care partners from the following sectors – hospitals, community care, community support services, community mental health and addictions, community health centres and long-term care – to develop innovative, collaborative solutions leading to more timely access to high quality services for the residents of Ontario and the North West LHIN. By supporting these important partnerships, LHINs are ensuring that Ontarians have access to an effective and efficient health care system that delivers improved health care results and a better patient experience.*

**Key Messages:**

- Because of LHINs, providers in the local health care system are **working together** to improve **access to quality care** for Ontario residents.

- Because of LHINs, the health care needs of **people in your community** are being identified, coordinated and addressed as a **truly integrated system**.
  - Local residents are receiving the right care at the right time in the right place, at the right cost.
  - Hospitals and community partners are working together to reduce ER wait times and deliver greater access to care.

- Because of LHINs, **local decisions** are being made to respond to local health care needs.
  - Every corner of this vast province has different health care needs. Those needs are best met through local decision-making.
  - By talking and listening to local health care providers and community residents, LHINs identify and bring to life local initiatives.
  - Health care decisions are focused on quality and with an understanding of the diverse and unique needs of each community.

- Because of LHINs, health service providers, such as hospitals, long-term care homes and community agencies, are being held **accountable for the taxpayer dollars** they are given.

Ongoing collaboration among the 14 LHINs will ensure that a consistent message is delivered across the province for provincial priorities; while the development of local communications plans to support specific projects or programs will ensure that local priorities are addressed.