
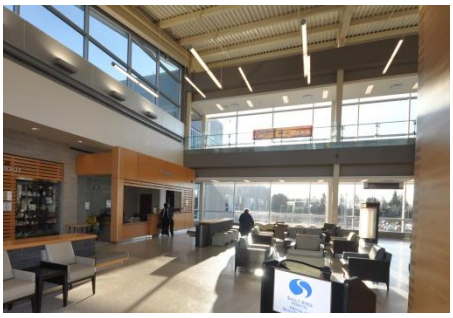

Sault Area Hospital 2017 Environmental Scan

June 30, 2017

SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

ACCREDITED WITH EXEMPLARY STANDING
ACCREDITATION AGRÉMENT CANADA

Mission, Vision and Values

Mission

Exceptional people working together to provide outstanding care in Algoma.

Vision

We will be recognized as the best hospital in Canada and an active partner in the best community health care system in the country.

iCare

Values

Integrity
We say what we mean and we mean what we say.

Compassion
We show concern and care for others.

Collaboration & Partnership
We promote teamwork.

Accountability
We are answerable for our actions and decisions.

Respect
We care about the well-being, dignity and uniqueness of everyone.

Excellence
We deliver our best every day and encourage innovation to continuously improve

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SAH'S ENVIRONMENTAL SCAN

What is an Environmental Scan?

Following the launch of Sault Area Hospital's new Strategic Plan (Plan) 2015-2020 in February 2015, SAH made the commitment that the Plan would be a living document and would be 'ever-greened'.

We committed to reviewing and refreshing the Plan each year to ensure it is always relevant and responsive to our changing environment.

One key input into the Strategic Plan is our Environmental Scan.

In preparation for ever-greening the Strategic Plan, we have updated our 2017 Environmental Scan with current information.

The SAH Environmental Scan is designed to help the organization and organization's leaders better understand the landscape at our organization, the health care landscape in the region, as well as critical issues and emerging trends in the field that could potentially benefit or threaten the organization in the future.

The Environmental Scan is intended to be utilized as a tool to assist with the decision-making process and strategic planning in the organization.

What does an environmental scan include?

The Environmental Scan should highlight both internal and external factors that could play a role in the future successes and/or challenges of the organization.

The Environmental Scan can include:

- social;
- economic;
- technological;
- political; or
- any other factor to help identify potential short/long-term shifts

The SAH Environmental Scan is designed to provide "evidence" about the direction of the organization, to raise awareness of issues, or to initiate a strategic discussion. The document is broken down by specific department/area. Each department/area can include:

- an overview of the area (including subsections, if required);
- general facts and figures;
- positive changes or challenges to the area;
- new investments, initiatives or programs;
- changes to demographics served in community; and
- new legislation impacting the area, etc.

Who is involved in the development of the Environmental Scan?

The attached 2017 Environmental Scan and Executive Summary represent the efforts of a number of SAH Programs, Departments and Committees including:

- Communications;
- Decision Support;
- Diagnostic Imaging;
- Emergency;
- Finance;
- Food Services;
- Human Resources;
- Infection Prevention & Control;
- Information Technology;
- Laboratory Services;
- Maternal/Child;
- Medicine;
- Mental Health & Addictions;
- Oncology;
- Pharmacy;
- Physician Recruitment;
- Planning & Risk Management;
- Rehab and Complex Continuing Care;
- Renal;
- Respiratory and Rehabilitation; and
- Surgical

Despite being a public document, the Environmental Scan is primarily meant as a support document and tool for the development of the SAH Strategic Plan updating process.

At latest, the Environmental Scan should be updated by May 1 annually to align with the revised SAH Corporate Planning Cycle.

Executive Summary

Executive Summary - Introduction

In 2013, Sault Area Hospital (SAH) developed an Environmental Scan (Scan), which identifies SAH's operating environment, future challenges and opportunities, and the organization's ability to achieve its vision, mission and goals. The Scan creates a context for decision-making to assist the Board of Directors' strategic planning. The Scan was also completed for 2015.

The 2017 Scan examines the relevant political, legal, economic, social and technological terrain now and where it is heading.

The SAH will be developing its annual refresh of the strategic plan to reflect 2017 to 2022.

In preparation for 'ever-greening' the strategic plan in 2017, SAH updated its 2015 Environmental Scan in June 2017 to reflect the most current data and changes since 2015.

The three most significant aspects of the current environment that will inform SAH's strategic direction and impact its ability to successfully achieve its strategic goals have not changed since 2015. These aspects are: the needs of the patient population being served, health care reform and an evolving operating environment, and the capability of the organization.

This Executive Summary serves as a companion document to the more detailed 2017 Environmental Scan.

Key strategic themes

- The three key strategic themes that emerge from the findings of the 2017 Environmental Scan align with the three components of the mission statement:

    1. Outstanding care – SAH's patient catchment will continue to be one of the most challenging in Ontario to serve;

    2. Working together – SAH's future operating context will look very different with the introduction of the revised Patient First Act and as demographic and financial constraints continue to compel health system reform; and

    3. Exceptional people – SAH's capabilities will need to be leveraged or refined to achieve our strategic direction.

EXECUTIVE SUMMARY - EXCEPTIONAL PEOPLE

Summary

SAH's aging workforce and shrinking recruitment pool, as well as fiscal restraint, leaves gaps in hard-to-fill specialty positions and creates recruitment and retention challenges. The government's mandate to use less of an acute care setting and a different funding model may impact the organization of services and governance structures. Our organizational capability may require a response that includes realignment of the services that we provide including what services we provide, how and who provides them, what volume is provided, and new or enhanced competencies to meet these challenges.

Strengths

The SAH has been recognized for meeting and exceeding standards, including Canada's Safest Employers Award (Silver Level), 2014 Quality Healthcare Workplace Award (Gold Level), Accreditation Canada - Accredited with Commendation (99% Compliance) and Excellence in Patient Care Award and International Health Care Organization of the Quarter Award from the Studer Group and Excellence in Patient Care Award for Emergency Department Performance at the 15th annual What's Right in Health Care® - Best Practices Conference, hosted by Studer Group.

Patient and Family Advisory Council

- The SAH has seen the Positive impact of Patient and Family Advisory Council

Employee Engagement

- Employee engagement is up 1% over the 2016/2017 target (65% vs. 64%)

Human Resources

- The Human Resources capacity, process, policy and practices are improving. There has been an improvement in recruitment practices and "hiring for fit";
- Recruitment of key leaders: Liz Ferguson, VP Clinical Operations and CNE; Dr. Andrew Webb, VP Medical Affairs; Dr. Derek Garniss, Chief Medical Information Officer
- Evolution of our Best Leadership program;
- Targeting internal talent and succession pool planning.

Physicians

- In 2017, there were 29,898 physicians working in Ontario, with 14,690 being family physicians, and 11,456 being specialists;
- On June 15, 2017, the MoHLTC announced that Physician Assistant (PA) Career Start grants to employ Ontario's 2017 PA graduates were available; and
- Financial support of $46,000, depending on geographic location, will be provided to help approved employers provide PA graduates with employment opportunities.
- Physician Relationship Framework is now in place
- Partnership established with Advisory Board Company to support physician leadership development

Registered Practical Nurses

- Registered Practical Nurses' membership with The Ontario College of Nurses increased from 44,195 in 2015 to 46,888 in 2016

Leadership Development Institutes

- Leadership Development Institutes continue quarterly, including invitations to key partners

Patient-Centred Flow

- Patient-Centered Flow Redesign work is being executed in alignment with the iCcare Way

iCcare Development Institutes

- iCcare Development Institutes launched, reinforcing key iCcare practices with staff, physicians and volunteers

Volunteers

- Volunteers contributed over 66,000 hours and have a satisfaction rate of over 98%
- Volunteer Association has raised 73% toward their commitment of contributing $200,000 towards a new CT scanner

Challenges

Physician engagement

- Physician engagement was worse than the previous year, falling 6% below target (56% vs. 62%) as measured by the annual NRC engagement survey;
- There is a wide range of shortages – physicians, specialists, dieticians, physiotherapists, and a need to expand fields of readily available data to support health care planning;
- In June 2017, Physicians voted in favour of a deal that will send contract disputes with the government to binding arbitration with no caps on negotiations.

Registered Nurses

- The Ontario College of Nurses is reporting a 2016 membership of 104,140 RNs which is a slight decrease from the 104,401 in 2015.

Human Resources

- There are challenges with the capacity and capability of organizational workforce planning, and our ability to fill temporary positions in Registered Nursing and Allied Health positions;
- Our overall rate of absenteeism continues to be above the provincial average; Fiscal restraint limits ability to invest and impacts executive development and retention, as well as compensation and bargaining with bargaining agents;
- SAH has an aging workforce with 22% able to retire immediately, an additional 14% to retire within 5 years and an additional 26% within 10 years – many in specialty positions.
- There are challenges in recruiting and retaining the right leaders for our organization and there are vacant positions.

EXECUTIVE SUMMARY - WORKING TOGETHER

Summary

Ontario's health system continues to undergo significant reform on three levels: funding, approach to caring for patients, and location of services. The expectation of efficiency and patient-based funding impacts how SAH is funded.

Provincial and local strategy continues to include an integrated and targeted focus on high-user, more complex patients as well as enabling more self-directed care and moving towards providing services in the community or in the patient's home.

This focus aligns with SAH's Strategic Plan and Mission.

SAH's future operating context continues to evolve as demographics shift and financial constraints continue to compel health system reform.

Performance and ability to support future growth are being challenged by an increasingly complex health care market, along with shifting political landscapes and ever tightening budgets. The extremely nuanced nature of health care information technology management is increasing the need for increased communication and technology governance.

Strengths

Governance

- Health system reform will continue to require skills in collaborative governance, innovation, business analysis and potentially a realignment of clinical expertise.

Physician

- SAH is working with City of Sault Ste. Marie, Group Health Centre and Algoma West Academy of Medicine on the SSM Physician Recruitment Program which has brought 133 physicians to practice in SSM.
- Less than 10% of recruited physicians have chosen to leave community prior or at the end of their 4 year commitment.
- SAH continues to collaborate with the Northern Ontario School of Medicine on specialty programs including Internal Medicine, Paediatrics, General Surgery and Psychiatry.
- SAH has an average of 25 medical learners in the facility every day
- In a PricewaterhouseCoopers Health Research Institute survey, 40% of US physicians surveyed said they could eliminate 11% to 30% of office visits through the use of mobile health technologies

NE LHIN

- NE LHIN is trying to increase primary care coordination, making mental health and substance abuse treatment services more accessible and targeting the needs of culturally diverse population groups
- Work has begun to scope SAH's role in the sub-region model, with the intent to partner with both the smaller hospitals in Algoma and other health service providers to improve patient care.

Information technology

- SAH is participating in the NELHIN regional approach to migrate to Meditech 6.1
    - Vision is to create a NewCo to provide services to 25 hospitals

- Wave 1 hospitals (North Bay, West Parry Sound, SAH) targeting go-live December 2018

- SAH`s strategic goal is to move to a full electronic patient record that can be shared seamlessly within our community. That move requires either an upgrade or replacement of the SAH current system.
- The North East Local Health Integration Network (NE LHIN) has expanded the initiative into the implementation of a regional solution rather than a single site solution.

Upcoming HIS will have the following benefits for patients:

- A single information system for data collection and management in NE LHIN
- Investment in a common hospital information system improves care for ALL patients – as it is the one tool that touches all patients as they receive hospital care across the region.
- Patients transferred from one hospital to another won't have to undergo duplicate tests or tell their "story" over and over. Their record will be complete and understood by all through technology that's aligned with that being used by the rest of the province.
- An opportunity for care standardization of best practices to enhance patient safety and outcomes, and to reduce harm.

Sault Ste. Marie Health Link

- SAH participated as a member of the Sault Ste. Marie Health Link
- A Health Link is a voluntary coalition of partners that treat Ontarians with complex needs. Participants in the Health Link Sault Ste. Marie initiative include, Group Health Centre, ARCH Hospice, SAH, other primary care organizations, Community Care Access Centre, community mental health and addictions, Algoma Public Health, the City of Sault Ste. Marie, the Innovation Centre, and Long Term Care.
- Based on the success of the pilot, a business case has been developed for 2017/18-2020/21 and a 17/18 funding and operating plan has been developed that will result in broader patient impact.

Partnerships

- SAH's partnership work continues
- Highlights: Physician Recruitment, Northern Ontario School of Medicine Joint Relations, ALT table, Med Staff Exec and SMT

SAH Foundation

- Co-branding launched by Sault Area Hospital Foundation – 'I give because iCcare'

Challenges

Physician

- In terms of physician recruitment, it is estimated that it could take 2 new physicians to replace 1 retiring physician.

Information Technology

- Identity Access Management technologies streamline the process of accessing systems and applications reducing password fatigue, frustration, and time wasted re-entering passwords needed – part of the VDI Strategy. Pilot project of VDI Strategy completed in partnership with our ADCP.
- Information and data is currently stored in various locations and formats that are not easily accessible or user-friendly.

- SAH needs to develop a network of secure, scalable electronic medical records (EMR) systems by working with Connecting Northern and Eastern Ontario (cNEO)The SAH`s Health Information System (HIS) needs to include the implementation of advanced clinical including Bedside Medication Verification, Physician and Nursing Documentation.
- Physicians need to be able to have secure access to medical information. Need to work with eHealth in connecting existing systems and building new platforms to give physicians and clinicians secure access to medical information in areas including: Diagnostic Imaging; Drug Profile; Medication Management and Ontario Laboratories Information System (OLIS).
- SAH has limited disaster recovery options which presents a risk should our main facility become compromised.
- The adoption of mobile devices has introduced new patient data risks at SAH. New mobile devices and services are able to collect and store patient data and generally in un-encrypted formats. Devices can be lost or stolen leaving patient data exposed.

NE LHIN

- The 2017/2018 focus of NE LHIN is transition of Community Care Access Centres.

EXECUTIVE SUMMARY - OUTSTANDING CARE

Summary

SAH's patient catchment continues to be one of the most challenging to serve. In 2016, the enumerated population of Algoma (District) is declining (-1.5%) but the number of seniors is increasing, particularly those in the 75 plus age group. From 2011 to 2016, Census results showed that the population of Sault Ste. Marie experienced a negative change in growth of -2.4%, compared to national growth of 5.0%. This reflects an almost 1,800 person reduction, from 75,141 in 2011 to 73,368 in 2016.

In 2016, 22% (16,410) of the Sault Ste. Marie population was 65 and over, compared with the provincial rate of 17%. The proportion of the population age 65 and over is projected to increase from 19% - 30% by 2036, a projected increase of 55%. Although Sault Ste. Marie's population has gone down, some of the smaller communities in the district east of the city have seen slight population increases. Garden River, Hilton Beach and Bruce Mines, are among those saw an increase.

Life expectancy in the North East is lower for both males (76.5) and females (81.4), than the Provincial average (m 79.2, f 83.6). Northeastern Ontario has one of the highest rates of rheumatologic heart disease, stroke, COPD, transport accidents, lung/colon/lymph cancer, chronic lower respiratory diseases, blood pressure, diabetes, and the lowest life expectancy at age 65 years. The North East region has more than double the intentional self-harm rate than Ontario (151 vs. 63 per 100,000). For general health risk factors, the North East region has significantly higher rates of people who report smoking and heavy drinking, as well as being overweight and obese and reporting high blood pressure, arthritis and diabetes.

The prevalence of multiple chronic conditions in the North East is significantly higher in comparison to the province. 21% percent of NE LHIN residents (aged 12+) have multiple chronic conditions (versus 15% for Ontario).

Strengths

Percutaneous Cardiac Intervention (PCI)

- In July, Dr. Eric Hoskins, Minister of Health and Long-Term Care for Ontario announced the government's support for bringing Stand Alone Percutaneous Coronary Intervention (SA PCI) or cardiac angioplasty to Sault Ste. Marie.

- Sault Area Hospital will receive a significant capital grant to support the implementation of our PCI program.
- Sault Area Hospital is already equipped with a state-of-the-art coronary angiography suite where our Cardiac Care Team performs more than 850 angiograms per year, but we have not been equipped to perform angioplasty. The funding announcement will support the development of an additional laboratory that will provide cardiac treatment and procedures at SAH.

Emergency Department

- SAH ED wait times were also on target at 91% vs. the budgeted 90%
- ED wait times for non-admitted patients averaged 2.7 hours (0.8 better than provincial average)

Finance

- Sault Area Hospital has experienced six consecutive years of surpluses after a decade of deficits;
- SAH Operational efficiency was "on target" for the 16/17 budget and operations resulted in a $0.3 million in operation surplus;
- HSFR positively impacted SAH when funding was increased by $5.5 million.
- Management and the Board's framework around leveraging our assets has evolved into a Guiding principles document. More work is required on this and will be part of the strategic plan refresh for 17/18.

Information Technology

- Current network technology supports voice, data, and wireless on one physical infrastructure;
- A Network Infrastructure Lifecycle Model was introduced in 2017 supported by 5 year licensing agreement;
- Wireless network is provides mobility support for a wide range of devices such as point-of-care workstations, tablets, handhelds, and laptops. Telephony environment was upgraded in 2017 and provides wired and wireless phone services with enhanced integration to other clinical systems including nurse call, telemetry, Code Blue alerting;
- Secure Email was introduced; security updates made to Firewall environment, smart management technologies were introduced to manage/control network traffic within the hospital.

Oncology

- Algoma's rates were statistically lower for prostate and liver cancer.

Rehab and Complex Care

- Senior-Friendly strategy developed that focuses on falls prevention, ALC avoidance, rehabilitative care, collaborative partnerships and cultural diversity

- With system focus on senior-friendly hospital care and identifying opportunities for sustainable alternate level of care practices, SAH work has enabled new teams, new work flow and new patient and family involvement in care transitions to match the patient's care needs and their rehabilitative potential to return home. This innovative approach to managing multiple aligned system priorities has gathered strength across the organization to commit to complex change management in the patient's interest.

Surgical

- Sault Area Hospital (SAH) will complete approximately 7,500 elective surgical cases in the Operating Room in 2017/18.

- SAH introduced non instrumented spine surgery in early 2017 allowing us to repatriate this patient population to the Algoma region to receive their care closer to home.

Mental Health and Addictions

- Mental Health and Addictions area is working with community partners to improve access to mental health and addictions services by reducing system fragmentation and duplication of service.
- Implementation of the Health Quality of Ontario Standards for major depression, as well as schizophrenia, will begin in Fall 2017.
- There is a newly established Mental Health and Addictions Patient and Family Advisory Council that is working to find opportunities for improvement.

Laboratory

- SAH Laboratory performs over 2.5 million procedures annually.
- "An estimated 60 to 70 percent of all decisions regarding a patient's diagnosis, treatment, hospital admission and discharge are based on laboratory test results" (Mayo Clinic).
- SAH operates one of six Regional Forensic Pathology Units (RFPU) in Ontario. This centre of excellence for forensic pathology is intended to improve forensic pathology capacity to service remote northern and First Nations communities.

Pharmacy

- With the pursuit of advanced clinicals through the Meditech 6.1 project, SAH will adopt many solutions to improve medication safety such as: Electronic Medication Administration Record (eMAR) with Barcode Medication Verification (BMV), Computerized Physician Order Entry (CPOE), and Electronic medication Reconciliation (eMed Rec).
- Both initial and ongoing education to staff and physicians on the technology implemented will reduce unsafe "work arounds" and reinforce best safety practices.

Diagnostic Imaging

- At a local level, the 64 slice CT scanner will be replaced in the next 3 years. This will allow SAH to meet the growth in this area, namely, slice parameters. Movement to a 128 or 256 slice scanner will enable faster throughput, different scanning techniques and faster diagnosis and treatment.

Patient and Family Engagement

- The Patient and Family Advisory Councils involve patient and family advisors in key decisions in the organization, ensuring patients and their families have timely access to information and can have their questions answered and seeing patients and their families as part of the health care team.

- In 2010, The Excellent Care for All Act (ECFAA) became law mandating putting Ontario's patients first by strengthening the health care sector's organizational focus and accountability.
- One model that institutions were already using and is gaining popularity across hospitals in Ontario is the Patient and Family Advisory Council." (The Change Foundation, Patient/Family Advisory Councils in Ontario Hospitals).
- The SAH PFAC maintains corporate SAH-PFAC meetings on a bi-monthly basis (Report Outs), and patient and family advisory councils for key SAH program areas:
    - Algoma District Cancer Program
    - Algoma Regional Renal Program

- Mental Health and Addictions

Communications and Social Media

- As of 2016, SAH is now engaging in the use of two social media platforms – Facebook and Twitter. The inclusion of social media as a tool for our communication strategy has allowed SAH to share our story from our prospective by featuring our successes and highlighting our people.

Future development of social media usage for SAH:

- Monitoring social media for issues important to your patients and community is good practice not only for reputational risk management but, more importantly, as a potential source of ideas to improve services and an opportunity to measure public sentiment as part of quality improvement processes.
- Quality improvement culture that moves beyond simply monitoring social media – and actively listens, acts on patients' ideas and concerns and communicates back to the public on actions taken – can build or reinforce a positive reputation.

Medicine Technology

- The trend toward regional care will continue dictating changes to processes and levels of care at SAH based on a standardized approach for all centres in the North East Local Health Integration Network (NE LHIN).
- Regional (LHIN-based) steering committees have been struck related to Stroke Care, Rehab and Complex Continuing care to implement recommendations around the region in these areas (e.g. defining use of beds and admission criteria, monitoring access, wait time and performance metrics). Changes implemented as a result of this work will result in opening of our 'borders' in order to accept and provide care to patients from anywhere within the entire LHIN in these areas.

Home care

- More care is being provided in the home than ever before, representing a significant shift in direction for Ontario health care. Initiatives enable us to care for increasingly higher need patients at home and in the community.

- In the 2015 Ontario Budget, the commitment to increase funding for home and community care was extended. Funding will be increased by 5% each year, investing another $750 million across the province over the next three years

Challenges

General Frontline

- In 16/17 Falls per 1000 at SAH were higher than the previous year.

Human Resources

- Executive Compensation:
    - Several pieces of legislation have been put in place in Ontario since 2010 with the intent of restraining compensation for senior executives in the Broader Public Sector. These are:
        - Public Sector Compensation Restraint to Protect Public Services Act – March, 2010
        - Strong Action for Ontario Act – March, 2012
        - Broader Public Sector Executive Compensation Act – March, 2015

- On September 6, 2016 the province put in place the Executive Compensation Framework Regulation. Since this time, government has sent directives asking hospitals to pause on implementation and subsequently introduced revisions to the legislation in early June, 2017.
- Retention and recruitment risk related to executive positions compounded by the fact that pay has been frozen since 2010. Recent changes to the legislation suggest that the timeframe to get to an approved executive framework will be quite extended.

- Leadership Recruitment & Retention:

  - Ongoing concerns with leadership turnover impacting our ability to deliver and sustain desired outcomes and results.
  - Deliberate implementation of a Best Leadership program as a strategic priority to support the ongoing development of leaders with both successes (Emerging Leaders Program) and challenges (continued turnover impacting sustainability of investments, capacity to make meaningful progress on developing internal talent and succession planning)
  - Most prevalent risk continues to be in clinical leadership at the Manager/Director level due to required knowledge and expertise and limited historical success in recruiting from outside our community. Some success in recruitment of clinical supervisor roles through the Emerging Leaders program and recent success in recruiting talent at Vice President and Director level roles. A continued need to focus on internal/community talent and strong succession planning.

- There remains a need to reduce the high number of sick days and overtime (OT) and create a healthy, well and safe environment.

Finance

- The $5.5 million increase received in 17/18 is expected to be temporary as it was driven by a large number of long stay patients discharged to Interim beds;
- SAH expects to require $53 million of capital equipment in the next ten years in addition to the significant investment in a new Health Information System occurring over the next two years;
- Health System Funding Reform continues to move Ontario's health care system away from global funding to Patient-Based Funding (PBF);
- Global funding will continue to be reduced in proportion as funding for Quality-Based Procedures (QBPs) increases.

Cost of Health Care

- Rising costs of extended health care benefits continue to be a concern to hospitals.
- Continuing with last year's slight increase in inflation factors for all of components of health care, this year the overall trend in cost again showed a slight increase.
- Looking at all of the health care components on a blended basis, insurers are using an average trend factor 11.81%, up from 11.69% last year.
- Hospital inflation factors have been consistently on the upswing from 2011 to 2014.
- The decrease continued again in 2016 with the insurer trend reducing from 9.70% in 2015 to 7.41%. Expected utilization trend of dental services has decreased slightly from 5.93% in 2015 to 5.86% this year.

Oncology

- Algoma's cancer mortality rate is higher than the Ontario rate.
- Cancer was the second leading cause of all mortalities in the Algoma District between 1998 and 2007.
- Algoma's lung and bronchus mortality rate is higher than the Ontario rate.

- In Algoma, Prostate, Breast, Lung and Colorectal Cancer account for 53.9% of all newly diagnosed cases, 53.2% of cases in Ontario, and 55.5% of cases in our Peer Group.

Medicine Technology

- The rate of technology has increased substantially in health care, both in patient care equipment and automation of records. In order to continue to improve efficiency (due to rising cost of health care), technology investments will be necessary to support SAH hospital care.
- Point of Care testing (e.g. measurement of common blood tests such as blood sugar) is needed to improve accessibility, turnaround time.
- In order to offer "standard of care" treatment to patients, investments will need to be made in types and scopes of services available (e.g. Cardiac intervention services – SAH is currently the only Ontario site that provides cardiac diagnostic services but no treatment, necessitating transfer to other centres).

Renal

- 53% of new renal failure patients are 65 years of age or older. Algoma has a high number of those 65 and older.

Emergency Department

- Although SAH ED wait times were also on target at 91% vs. the budgeted 90%, the ED is being frequently used to evaluate and treat patients for acute medical problems and severe injuries; it is also a safety net for patients who lack access to primary health care and community services.
- Increased ED visits and ICU volumes for persons 45 years of age and over is associated with a greater proportion of illness conditions presenting with an increased use and allocation of more services, medications, and mid-level providers such as occupational therapists, physiotherapists, pharmacists, palliative care specialists, dietician, respiratory therapists, nurse practitioners

Surgical

- Sault Area Hospital has been designated a level 3 vascular centre; recruitment of a vascular surgeon will be required in the near future.

Mental Health and Addictions

- The District continues to have ongoing challenges with the psychiatric workforce; based on population, there should be 12-14, we currently have 10. Recruitment efforts will continue.
- The number of people in Algoma over age 75 is anticipated to increase by over 50% by 2030. A significant percentage of these individuals will experience age-related mental illness. There is a rising risk population locally. Reducing readmissions to Mental Health and Addictions is required

Laboratory

- The new Healthcare Information System project will be a major undertaking for the laboratory, as the system build is one of the largest in the project. Substantial dedicated time and resources will be required.

- Institute for Quality Management in Healthcare (IQMH) comprehensive accreditation assessment visit is due and will be conducted in fall of 2017.

- Quality Management Partnership (QMP) requirements continue to be implemented, and will continue over the next 2 years.

- Recruitment of Pathologists will be a key focus for the laboratory as we look to provide a regional service to Algoma and the NELHIN.

- Capital needs of this highly automated program continue, with major capital investments continuing throughout the next 1-5 years.

- eHealth Ontario strategies must be prioritized with the new HIS work to ensure alignment with provincial reporting requirements.

Pharmacy

- SAH is lagging in its adoption of technology to improve the safety of the medication management process.
- The implementation of IV SMART pumps would add a layer of safety to the administration of IV therapies which have a higher risk of harm to patients when errors do occur.
- Oral chemotherapy currently comprises 40% of ADCP treatments and will continue to grow. This presents a challenge of safely managing these high risk medications in partnership with community pharmacies or by building internal outpatient dispensary for oral chemotherapy.
- Genetically targeted therapies will continue to grow in number and will be introduced at a premium cost. So although oral therapies will grow in number, the remaining systemic treatments will be introduced at a premium cost. Biosimilar "generic" medications are trending in the US currently, but the legislation is less clear in Canada at this time so costs will continue to rise for these products.
- Drug shortages will continue into the foreseeable future and beyond. As hospitals seek to drive drug costs down, sole award contracts lead to fewer manufacturers of generic medications leaving the marketplace vulnerable to shortages.

Housing and Long Term Care

- In April 2017, 655 people are on the LTCH placement waitlist.

Infection Control

- In 16/17, *Clostridium difficile* per 1000 were worse than the previous year.

Executive Summary - Changes to NE LHIN

Changes Related to Home and Community Care

- On May 31, 2017, home and community care services and staff transferred from the North East Community Care Access Centre (CCAC) to the North East Local Health Integration Network. This change was part of the Government of Ontario's Patients First: Action Plan for Health Care.
- In January 2017, the Ministry of Health and Long-Term Care endorsed five sub-region boundaries proposed by the North East LHIN.

Strengths

- Support and improve access to home and primary care
- Help put patients and families at centre of health care
- Increase focus on cultural sensitivity
- Many of the demographic challenges the NE LHIN faces are the same challenges SAH faces

Challenges

- The challenge for local LHIN to oversee new responsibilities will require time and adjustment;
- Concern about the size of the North East LHIN and the Algoma sub-region and the impact that could have on health care choices;
- New challenges regarding patient privacy; and
- Challenge for SAH in understanding the NE LHIN's new responsibility means for them

Executive Summary - Political Environment

Changes related to local political environment make SAH representation uncertain

- Long-time Member of Provincial Parliament David Orazietti resigned from cabinet on December 16, 2016, effective January 1, 2017.
- Local city counsellor Ross Romano ran a successful campaign for the Progressive Conservatives winning the provincial by-election in Sault Ste. Marie, securing the party's first victory in the Northern Ontario riding since 1981. The victory didn't change the balance of power in the legislature.
- During the by-election, some candidates utilized factually incorrect information about the SAH as campaign issues which were corrected by an open letter to the media from our CEO.
- Romano, a PC representative, may experience challenges gaining support for local issues (including SAH needs) with Kathleen Wynne's Liberal provincial government.

Executive Summary – Legislation

Changes related to legislation that could impact SAH

The Protecting Canadians from Unsafe Drug Act

- 2017 amendments allow Health Canada to identify, assess and respond more quickly to safety issues that emerge once a drug comes on the market

Access to Cannabis for Medical Purposes Regulation

- Replaced the Marijuana for Medical Purposes Regulation in August 2016.
- In a hospital setting, the person in charge of the hospital can allow fresh or dried marijuana or cannabis oil to be administered to a patient or, sold or provided to a patient or an individual responsible for the patient

Medical Assisted Dying

- On May 10, 2017, Ontario's Medical Assistance in Dying Statute Law Amendment Act, 2017 came into force addresses areas relevant to medical assistance in dying that fall under provincial jurisdiction.
    - Provides greater clarity and legal protection for health care providers (including institutions and clinicians) as well as patients navigating medical assistance in dying.
    - The legislation also establishes a new role for the coroner in overseeing medically assisted deaths.
- There is confusion regarding the language in the act which has been identified as not clinical enough

Bill 119, Health Information Protection Act, 2015

- On September 16, 2015, the Minister of Health & Long-Term Care (the Minister) introduced Bill 119, Health Information Protection Act, 2015 which would improve privacy, accountability, and transparency in health care. Proclaimed in May 2016 to enhance the protection of personal health information.
- Some of the changes under Bill 119 would include:
    - Making it mandatory to report privacy breaches to the Information and Privacy Commissioner, and to relevant regulatory colleges; and
    - Doubling the maximum fines for offences from $50,000 to $100,000 for individuals and from $250,000 to $500,000 for organizations.

Quality Care Information Protection Act (QCIPA) Review

- The Quality Care Information Protection Act, 2004 (QCIPA) came into force on November 1, 2004.
- The Quality of Care Information Protection Act, 2016 (QCIPA 2016) highlights definitions for "critical incident," "health facility," *Quality of Care Committee* (QCC), *Quality of Care Functions, and Quality of Care Information.*

Accessibility for Ontarians with Disabilities Act (AODA), 2005

- The Accessibility for Ontarians with Disabilities Act (AODA) 2005 provides for mandatory progressive change to help improve the lives of people with disabilities. Hospitals and other organizations will have to meet certain accessibility standards in five areas: 1. Customer service; 2. Employment; 3. Information and communications; 4. Transportation; and 5. Design of public spaces

By December 31, 2017, all hospitals need to:

- Make new or redeveloped public spaces accessible
    - outdoor public use eating areas
    - public outdoor paths of travel
    - on and off street parking areas
    - accessible service counters
    - fixed waiting lines
    - waiting areas with fixed seating

Workplace Violence Prevention in Health Care Project

The health care sector is the largest sector affected by violence in the workplace. 56% of lost-time injuries due to workplace violence in the hospital sector occur among Registered Nurses. On May 15, 2017, the Ontario Ministry of Health and Long-Term Care and Ministry of Labour released a progress report on the first year of its joint Workplace Violence Prevention in Health Care project. The focus of the first year has been on reducing the risk of violence for nurses working in hospitals.

The progress report includes 23 recommendations. The recommendations include several process enhancements that are aimed at hospitals, such as:

- Including workplace violence indicators in hospitals' quality improvement plans (QIPs);
- Providing increased supports for patients with known aggressive behaviours;
- Seeking patient, family and staff input about triggers and interventions; and
- Creating a reporting system for workplace violence incidents.

The Protecting Patients Act, 2017

The Protecting Patients Act received Royal Assent on May 30, which includes legislative amendments to:

Sexual abuse

- Expand list of acts of sexual abuse that will result in the mandatory revocation of a regulated health professional's certificate of registration
- Remove the ability of a health regulatory college to impose restrictions that would allow a regulated health professional to continue practicing on patients of a specific gender
- Require that more information regarding the current and past conduct of regulated health professionals is available to the public

Elderly

- Improving and modernizing Elderly Persons Centres to help seniors stay healthy, active and engaged
- Making it easier and more convenient for people to receive coverage under the Ontario Drug Benefit (ODB)
- Continuing to ensure that community laboratory services are safe and effective \

Fair Workplaces and Better Jobs Act, 2017 (Bill 148)

- On June 1, 2017, Ontario introduced legislation to create more opportunity and security for workers by hiking the minimum wage, ensuring part-time workers are paid the same hourly wage as full-time workers, introducing paid sick days for every worker and stepping up enforcement of employment laws.

Executive Compensation Regulations

- The government has enhanced the Regulation to align compensation programs with the expectations communicated from February 3, 2017.
- Employers are required to set out the maximum rate of increase to their overall executive compensation envelope to ensure transparency.
- Overseeing Minister approval will be required on two components: comparator organizations and maximum rate of increase
- Annual adjustments to salary and performance-related pay caps may not exceed the lesser of the provincial public sector wage trend and the average rate of increase of an employer's non-executive managers and must be submitted by September.

This regulation may have an impact on the SAH's ability to recruit and retain talented executives.

Bill 56, Ontario Retirement Pension Plan Act, 2014

- In May 2015, Bill 56, Ontario Retirement Pension Plan Act, 2014 received Royal Assent. The legislation created the Ontario Retirement Pension Plan (ORPP) for employees who do not have a workplace pension. ORPP was to be introduced in 2017 and be funded by equal contributions from both employers and employees equal to 1.9% of salary.
- Following the October 2015 federal election, working collaboratively with the federal government and other provinces and territories, Ontario advocated for a national solution for retirement security that benefits all Canadians.
- As a result of the June 20, 2016 meeting, the government of Ontario, along with eight other provinces and the federal government, reached a historic agreement in principle to enhance the CPP. This means Ontario no longer needs to proceed with the ORPP.

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Internal Environment

Internal Environment – Sault Area Hospital (SAH) snapshot

SAH continues to undergo a cultural transformation. These changes enable increased focus on patient-centred care, senior friendly care, higher acuity and specialty care, continuous improvement, and quality.

Sault Area Hospital (SAH) is an acute care and specialty services hospital with 252 beds serving a total catchment population of approximately 114,000 across the Algoma District.

Approximately 1650 active employees work at SAH and about 389 physicians (including 173 locums) have privileges at SAH. Over 600 volunteers contribute about 66,000 hours annually. On any given day, approximately 50-60 volunteers are on site to assist patients and visitors.

In April 2015, SAH participated in an onsite review by Accreditation Canada and was initially awarded 'Accredited with Commendation' status. After undertaking additional work, in November 2015, SAH standing was changed to 'Accredited with Exemplary Standing.' This standing remains valid until 2019.

In 2017, SAH was awarded Canada's Safest Employers Award (Silver) in the Wellness Category.

In 2016-17, SAH reduced Emergency Department, hip and knee replacement, and MRI wait times below the provincial average.

Through the Algoma District Cancer Program, SAH provides comprehensive cancer treatment including chemotherapy, biotherapy, and radiation therapy. The SAH has a special partnership with the Northeast Cancer Centre in Sudbury. While Radiation Oncology affiliation exists as a solitary unit in SAH, the unit is an integrated program that spans from the Sault to Sudbury – a dedicated multi-disciplinary team where support runs in both directions. Local Radiation Oncologists provide clinical leadership and consultation, and oversee treatment at SAH.

Two CT scanners and an MRI are included among the hospital's diagnostic equipment. Other diagnostic services include nuclear medicine and a state-of-the-art cardiac angiography suite.

Care is being transformed at SAH through patient-centered flow efforts. There are now 40 patient and family advisors, including ADCP, Renal, Mental Health and Addictions and Corporate Councils to help make improvements throughout the organization. In addition, SAH has a *senior-friendly* strategy developed that focuses on falls prevention, ALC avoidance, rehabilitative care, collaborative partnerships and cultural diversity

Internal Environment – Current Strategic Direction, Performance Against Key Indicators

Sault Area Hospital's strategic direction for 2016 to 2021 focuses on exceptional people, working together and outstanding care.

Sault Area Hospital Strategic Plan – 2016-2021

In February 2015, SAH updated its Strategic Plan (Plan) for the period 2015 to 2020. Almost 500 people contributed to the original plan including patients, family members, staff, physicians, volunteers, members of the community, bargaining agents, referral and peer hospitals, primary care providers, health policymakers, local and provincial members of government and many others.

The new Plan closely aligns to the SAH Mission statement – Exceptional people working together to provide outstanding care in Algoma.

The Plan is a living document which will be reviewed and refreshed annually to ensure it continually adapts to the ever-changing health care landscape.

In November 2016, SAH updated its Strategic Plan (Plan) for the period 2016 to 2021

Vision – We will be recognized as the best hospital in Canada and an active partner in the best community health care system in the country.
Being the best means:

- Providing quality care, every day, everywhere;
- Being a great place to work, volunteer and practice medicine;
- Having strong partnerships within our community, region and province; and
- Using our resources wisely to reinvest in programs and services at SAH.

Our Mission – Exceptional people working together to provide outstanding care in Algoma.

Our iCcare Values – We believe that our daily actions, interactions and decisions will reflect:

- Integrity – We say what we mean and we mean what we say;
- Compassion – We show concern and care for others;
- Collaboration & Partnership – We promote teamwork;
- Accountability – We are answerable for our actions and decisions;
- Respect – We care about the well-being, dignity and uniqueness of everyone;
- Excellence – We deliver our best every day and encourage innovation to continuously improve.

Quality Improvement Plan 2017/2018

The Excellent Care for All Act, 2010 (ECFAA) requires that every year, health care organizations develop a Quality Improvement Plan (QIP) for the following fiscal year and make it available to the public. QIPs must be in place, publicly posted, and submitted to Health Quality Ontario (HQO) each year by April 1st.

Developed in partnership with SAH Patient and Family Advisors and other key stakeholders, our 2017/2018 QIP focuses on 12 indicators, 4 of which are priority indicators recommended by Health Quality Ontario because they represent organizational and sector-specific priorities system-wide and 6 custom indicators chosen to reflect our local initiatives providing consistency with our organizational goals:

1. Employee Engagement
2. Physician Engagement
3. Unplanned Readmissions (selected HIGs)
4. 30 Day Readmission for MH&A
5. Medication Reconciliation at Admission
6. Medication Reconciliation at Discharge
7. ALC Rate
8. Patient Experience
9. ER Wait Time for Admitted Patients
10. *Clostridium difficile* infection (CDI)
11. Falls (Rate/1000 Patient Days)
12. Pressure Ulcers on Complex

The QIP sets out the initiatives and ideas for change that SAH will undertake to continue to improve safety, effectiveness, accessibility, integrated care, and the patient experience.

SAH continues to make improvements

- Canada's Safest Employers Award (Silver Level)
- 2014 Quality Healthcare Workplace Award (Gold Level)
- Ebola response preparedness
- Accredited with Commendation – 99%+ compliance
- Impact of Patient and Family Advisory Council
- Excellence in Patient Care award and International Health Care Organization of the Quarter Award
- Improved wait time results

Quality improvement Results

Strengths

- Employee engagement is up 1% over the 2016/17 target (65% vs. 64%)
- Operational efficiency was on target for the 16/17 budget
- ED wait times were also on target at 91% vs. the budgeted 90%

Challenges

- Physician engagement was worse than the previous year 6% below target (56% vs. 62%)
- In 16/17, Conservable day, *Clostridium Difficile* Infection and Falls per 1,000 were all higher than the previous year.
- Ongoing concerns with leadership turnover impacting our ability to deliver and sustain desired outcomes and results.

- Most prevalent risk continues to be in clinical leadership at the Manager/Director level due to required knowledge and expertise and limited historical success in recruiting from outside our community. Some success in recruitment of clinical supervisor roles through the Emerging Leaders program and recent success in recruiting talent at Vice President and Director level roles. A continued need to focus on internal/community talent and strong succession planning.
- There remains a need to reduce the high sick and over-time (OT) rates.

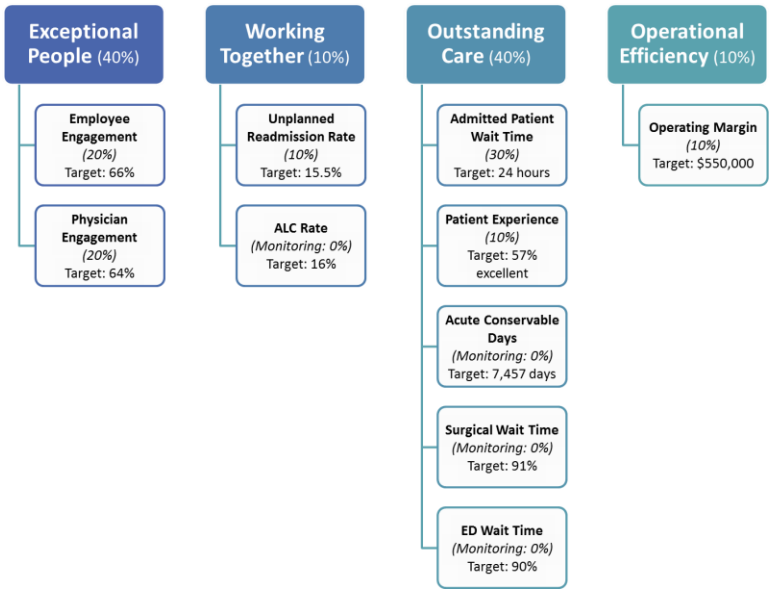
2016/2017 Results

Pillar	Goal	Type	Reporting Period	Current Result	F2016/17 Result	F2016/17 Target	Last Year
Exceptional People (40%)	**Employee Engagement (20%)**		**Mar 2017**	**65%**	**65%**	**64%**	**61%**
	Physician Engagement (20%)		**Mar 2017**	**56%**	**56%**	**62%**	**60%**
Working Together (10%)	**Unplanned Readmissions (10%)**		**Dec 2016**	**17.3%**	**16.5%**	**15.5%**	**17.1%**
Outstanding Care (40%)	**Admitted Patient Wait Time (40%)**		**Mar 2017**	**27.7**	**27.7**	**24.0**	**40.1**
	Patient Experience		**Mar 2017**	**55%**	**55%**	**n/a**	**n/a**
	Surgical Wait Times Within Target		Mar 2017	92%	**88%**	90%	88%
	ED Wait Times Within Target		Mar 2017	90%	**91%**	90%	89%
	HSMR		Mar 2017	108	100	96	106
	Conservable Days - Acute		Mar 2017	1,172	9,453	7,700	8,445
	Clostridium Difficile Infection (CDI)		Mar 2017	0.25	0.24	0.18	0.23
	Fall per 1,000 (including MH)		Mar 2017	6.6	7.9	5.6	6.7
	ALC Rate		Mar 2017	15%	25%	23%	25%
Operational Efficiency (10%)	**Operating Margin ($000s) (10%)**		**Mar 2017**	**$772**	**$267**	**$0**	**$1,117**

Legend:
- On Target
- Same or Better Than Previous Year
- Worse Than Previous Year

2017/18 Targets

The following targets were approved at the November 2016 Board of Directors meeting.



Internal Environment – Sault Area Hospital Financial Position

Sault Area Hospital has experienced six consecutive years of surpluses after a decade of deficits.

Discussion

The Sault Area Hospital (SAH) received a $44 million Working Capital relief fund over three years with the objective to bring its working capital to $0 by 2026. SAH received its final installment in 2013/2014.

Management and frontline continue to work together to improve the financial position of the SAH in order to reinvest in innovation, education, and capital which will improve the quality of care.

Highlights

- SAH's 2016/2017 operations resulted in an operating surplus of $0.3 million, compared to $1.1 million in 2015/2016.
- HSFR has positively impacted SAH in 2017/2018 when SAH's funding was increased by approximately $5.5 million. However, the increase is expected be temporary with a substantial decline in 2018/2019 as the increase was driven by a one-time increase in patient volumes when a large number of long stay patients were discharged to Interim Long Term Care beds.
- SAH expects to require $53 million of capital equipment in the next ten years in addition to the significant investment in a new Health Information System occurring over the next two years.

Challenges

- Management and the Board's framework around leveraging our assets has evolved into a Guiding principles document. More work is required on this and will be part of the 17/18 strategic plan refresh.

Internal Environmental – Health Human Resources

Delivering on our mission of exceptional people and outstanding care includes effective strategies to ensure the right resources at the right time with the right skills.

Discussion

The engagement, development, retention and recruitment of skilled employees within an environment of fiscal restraint is key to quality patient care and the overall achievement of SAH's mission, vision and goals.

Highlights

- An aging workforce with approximately 22% of SAH current workforce able to retire immediately, and an additional 14% eligible to retire within 5 years, 26% within 10 years, many of whom are in specialty nursing and registered medical technician positions;
- The current provincial fiscal reality, the impact of legislation on executive compensation, and potential future legislation that may impact the ability to attract and retain senior leaders;
- Fiscal restraint and focus on integration resulting in impacts to labour relations with bargaining agents interested in retaining members and protecting job security;
- The financial and operational impact of collective agreement language in trying to navigate and respond to consistent change in the environment.

Strengths

- Improved Human Resources capacity, process, policy and practices;
- Improved recruitment processes and practices, including movement towards hiring for fit;
- Introduction of enhanced and formalized organizational development initiatives;
- Evolution of the Best Leadership Program, including continued success of Emerging Leaders Program.

Challenges

- Capacity and capability to do effective workforce planning;
- Ability to fill temporary positions in Registered Nursing and Allied Health related fields.
- Executive Compensation:
    - Several pieces of legislation have been put in place in Ontario since 2010 with the intent of restraining compensation for senior executives in the Broader Public Sector. These are:
        - Public Sector Compensation Restraint to Protect Public Services Act – March, 2010
        - Strong Action for Ontario Act – March, 2012
        - Broader Public Sector Executive Compensation Act – March, 2015
    - On September 6, 2016 the province put in place the Executive Compensation Framework Regulation. Since this time, government has sent directives asking hospitals to pause on implementation and subsequently introduced revisions to the legislation in early June, 2017.
    - Retention and recruitment risk related to executive positions compounded by the fact that pay has been frozen since 2010. Recent changes to the legislation suggest that the timeframe to get to an approved executive framework will be quite extended.
- Leadership Recruitment & Retention:
    - Ongoing concerns with leadership turnover impacting our ability to deliver and sustain desired outcomes and results.

- Deliberate implementation of a Best Leadership program as a strategic priority to support the ongoing development of leaders with both successes (Emerging Leaders Program) and challenges (continued turnover impacting sustainability of investments, capacity to make meaningful progress on developing internal talent and succession planning)
- Most prevalent risk continues to be in clinical leadership at the Manager/Director level due to required knowledge and expertise and limited historical success in recruiting from outside our community. Some success in recruitment of clinical supervisor roles through the Emerging Leaders program and recent success in recruiting talent at Vice President and Director level roles. A continued need to focus on internal/community talent and strong succession planning.

- There remains a need to reduce the high number of sick days and overtime (OT) and create a healthy, well and safe environment.

Opportunity

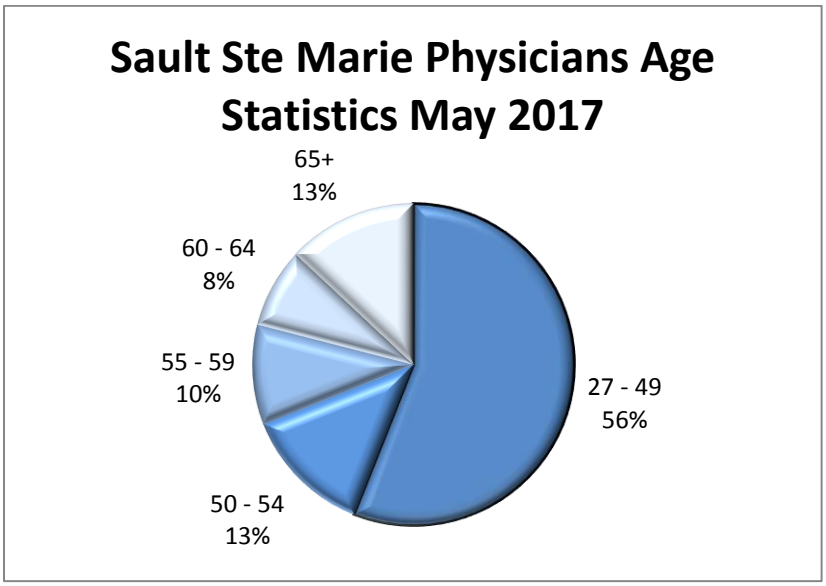
- Data, tools, skills and process for effective workforce planning given current demographics and projected future needs that are being addressed through the implementation of centralized workforce planning;
- Creation of programs and investment in resources to target internal talent to succession plan into leadership and specialty areas;
- Development of and investment in, robust learning programs for employees.

Threat

- Fiscal restraints and ability to invest in development and retention of human resources;
- Percentage of staff able to retire now or in the next 5\10 years, particularly in specialty nursing and registered technologist positions.

Physician recruitment

- The Sault Ste. Marie Physician Recruitment and Retention Program is comprised of representatives from SAH, the City of Sault Ste. Marie (City of SSM), the Group Health Centre (GHC), and Algoma West Academy of Medicine. It has an annual budget of $200,000 with contributions of $80,000 from the City of SSM and $60,000 each from SAH and GHC.
- With a recruitment target set at 8 physicians per year, the Program has brought 133 physicians to practice in Sault Ste. Marie since 2002. Of these recruited physicians, less than 10% have chosen to leave the community prior to or at the end of their four year commitment.
- Just over half of all physicians practicing are under the age of 50. It has been estimated that it could take 2 new physicians to replace 1 retiring physician.



Source: Sault Ste. Marie Physician Recruitment & Retention database

Northern Ontario School of Medicine

- Many of the physicians practicing at SAH are active NOSM faculty. SAH participates in NOSM's 2-year Family Medicine Residency Program. On July 1, 2017, SAH welcomes 5 incoming residents from this Program. SAH has offered an annual PGY3 Anesthesia resident position through NOSM for the last three years. SAH also has a part time Paediatrics resident.
- SAH has also collaborated with NOSM to participate in many other specialty programs including Internal Medicine, Paediatrics, General Surgery, and Psychiatry in Sault Ste. Marie.
- SAH continues to receive third year NOSM students through the Comprehensive Community Clerkship as well as elective and core rotations from both NOSM and other medical schools across Canada and abroad.
- On average, SAH has 25 medical learners training with us every day.
- SAH hosted the Psychiatry CaRMs interviews in 2017. The local psychiatry NOSM faculty has also been directly involved in OSCE preparation and curriculum development.
- Dr. Jonathan DellaVedova, Paediatrician, has been appointed the NOSM Postgraduate Wellness Lead Clinician. Dr. DellaVedova completed medical school at NOSM as part of the charter class and has been actively involved in curriculum development since returning to Sault Ste. Marie to practice his specialty.
- Physician faculty members are also members of the Sault Ste. Marie Academic Medical Association (SSMAMA). SSMAMA's mandate includes clinical teaching, faculty development, and scholarly activity. The association has formulated a new research office at Algoma University and funded many local physician research projects.

References

http://www.nosmsp2020.ca/

Ontario Hospital Association. Provincial Health Human Resources Work Plan 2015-2020

Internal Environment – Overview of Technology Deployment

The Information Technology department will focus on improving existing applications, infrastructure, and business systems to ensure that major investments are utilized as efficiently and effectively as possible before introducing additional technologies.

Discussion

Performance and ability to support future growth are being challenged by an increasingly complex health care market, along with shifting political landscapes and ever-tightening budgets. Increasing organizational complexity and extremely nuanced nature of health care information technology management are placing greater emphasis on the need for increased communication and technology governance across the organization and with external partners.

Strengths

- Corporate network technology is current and incorporates voice, data, wireless on one physical infrastructure which allows Sault Area Hospital (SAH) the flexibility to deploy services where needed without investing in multiple networks.
- A Network Infrastructure Lifecycle Model was introduced in 2017 supported by 5 year licensing agreement. This will ensure our Network environment remains current.
- A wireless network is deployed throughout the SAH campus providing mobility support for a wide range of devices such as point-of-care workstations, tablets, handhelds, and laptops. Main components with the Wireless network were upgraded in 2016.
- Computing (server) environment provides current Virtualization Technology to our server and data centre environments. This minimizes outages and unplanned downtime events for major systems such as Meditech and PACS. Hardware updates completed in 2017.
- The telephony environment was upgraded in 2017 and provides wired and wireless phone services with enhanced integration to other clinical systems including nurse call, telemetry, and Code Blue alerting.
- Secure Email was introduced in 2016 to support the secure exchange of PHI via the eHealth ONE Mail service.
- Security Updates to our Firewall environment in 2016 enhance our protection strategy against Malware and other evolving threats.
- Smart management technologies were introduced to manage/control network traffic within the hospital.
- The Central Storage environment was upgraded in 2014 which introduced improved performance and data security – improved data redundancy capabilities.
- Introduced disk based back-up environment.
- Implementation of Physician Office Integration (POI).

Challenges

- Consistent data sharing controls/policies and standardized desktop delivery (VDI).
- The current security/privacy standards for wireless access controls require updating.

Strategic priorities

- Identity Access Management technologies streamline the process of accessing systems and applications reducing password fatigue, frustration, and time wasted re-entering passwords – part of the VDI Strategy. Pilot project completed in partnership with our ADCP Physician team re-enforce the workflow efficiencies that are needed in this area.

- Information and data is currently stored in various locations and formats that are not easily accessible or user-friendly. The result is wasted cycles looking for information that may not be updated and completely accurate. There is an opportunity in the management of documents and information coupled with tools to present this information using Intranet and portals.
- Work with Connecting Northern and Eastern Ontario (cNEO), from a provincial view to develop a network of secure, scalable electronic medical records (EMR) systems. These systems will enable patients and authorized health care providers to access secure essential health records when and where they are needed.
- Set the Health Information System (HIS) future direction to include the implementation of advanced clinical including Bedside Medication Verification, Physician and Nursing Documentation.
- Work with eHealth in connecting existing systems and building new platforms to give physicians and clinicians secure access to medical information. Areas include Diagnostic Imaging; Drug Profile; Medication Management and Ontario Laboratories Information System (OLIS).
- Work with the local community to develop a strategy to view and share patient-related data in a timely and secure manner.

Threats

- Currently, SAH has very limited disaster recovery options which presents a risk should our main facility become compromised. The plan is to work with community and regional partners to capitalize on existing infrastructure such as modern data centre facilities and the eHealth network. A disaster recovery strategy would allow for offsite replication of data and systems needed to support the business operations of SAH.
- The adoption of mobile devices has introduced new patient data risks. New mobile devices and services are able to collect and store patient data and generally in un-encrypted formats. Devices can be lost or stolen leaving patient data exposed. An end-to-end strategy for handling end user devices and tools would minimize these risks.

External Environment

External Environment – Ontario, Algoma and Sault 2016 Census Information

Discussion

The Algoma area faces significant challenges as its population continues to age and many health risk factors and chronic condition rates are the highest in the province and are continuing to increase. The 2016 Census products provide statistical information about the population, age and sex, type of dwelling, families, households and marital status, language, income, immigration and ethno cultural diversity, housing, Aboriginal peoples, education, labour, journey to work, language of work and mobility and migration, as measured in the census program. Specific breakdowns relating to health of citizens of Ontario, Algoma and Sault Ste. Marie have not yet been released.

Ontario Statistics (2016)

Although the population of Ontario is growing, Canada's most populous province has been growing more slowly than the country as a whole.

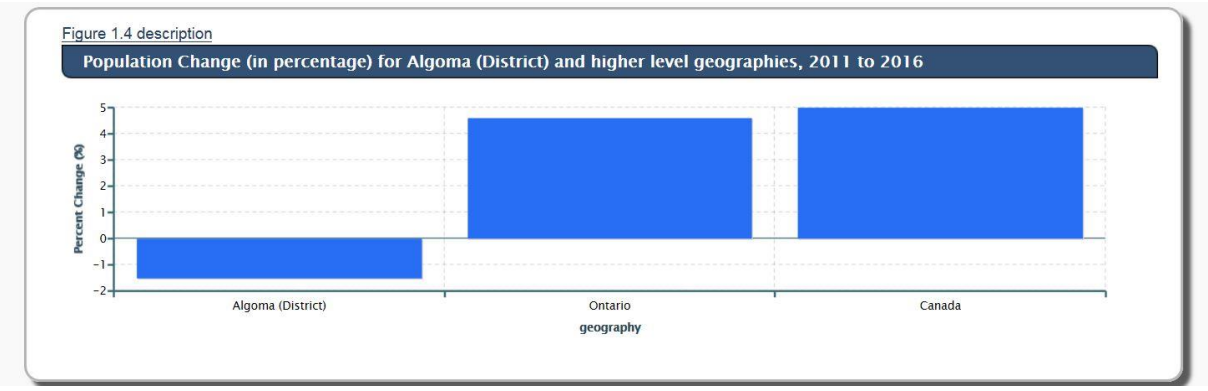
The growth rate for Ontario, home to some 13.4 million people, came in at just 4.6 per cent, down from 5.7 per cent in 2011 — the first time since the Second World War that in two straight census periods, Canada's most populous province has been growing more slowly than the country as a whole.

Ontario recorded its lowest population growth rate since 1986. People were leaving the province at twice the rate they had previously.

In terms of immigration, Ontario typically attracts more people than any other province. In the fourth quarter of 2015 alone, Ontario saw a net international migration gain of 12,845, compared to a net loss of 3,390 in the same quarter a year earlier, according to Statistics Canada data.

People tend to go where the jobs are; in 2016 Ontario's unemployment rate was 6.5 per cent, lower than the national rate and well below Alberta's jobless number of 8.1 per cent

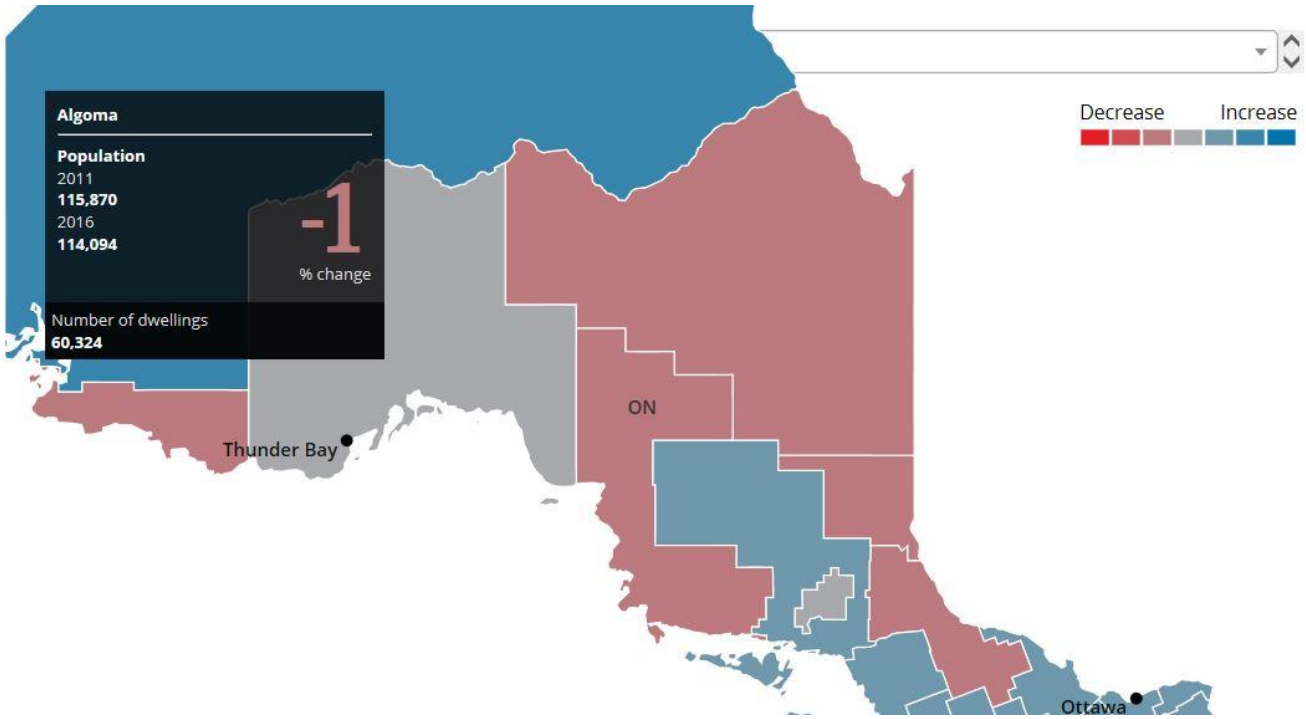
Ontario remains Canada's most populous province with 13.4 million residents, representing 38.3 per cent of the population. Its rate of growth was a modest 4.6 per cent, owing in part to lower immigration levels.



Algoma Statistics (2016)

Population is dropping in the Algoma region

- In 2016, the enumerated population of Algoma (District) was 114,094, which represents a change of -1.5% from 2011. This compares to the provincial average of 4.6% and the national average of 5.0%.
- The Algoma population as a whole is decreasing (-1.5%) but the number of seniors is increasing, particularly those in the 75 plus age group.
- The median age will continue to increase, more so for women
- The land area of Algoma (District) is 48,814.88 square kilometres and the population density was 2.3 people per square kilometre.
- In 2016, there were 51,071 private dwellings occupied in Algoma (District), which represent a change of 1.0% from 2011.



Sault Ste. Marie Statistics (2016)

New census data shows the population of Sault Ste. Marie fell below the national growth rate over the last five years.

- Statistics Canada released the first batch of numbers from the 2016 census and the population of Sault Ste. Marie decreased by 2.4 per cent since the last census in 2011.
- The city's growth rate was below the national growth rate of 5.0 per cent, while the population of Ontario increased by 4.6 per cent.
- When the census was taken May 2016, the population of Sault Ste. Marie was 73,368, compared with 75,141 from the 2011 census.
- According the Statistics Canada's latest data, Sault Ste. Marie's population is 73,368, down from 75,141 in 2011. The 2.4 per cent decline in population equates to almost 1,800 people.
- Although Sault Ste. Marie's population has gone down, some of the smaller communities in the district east of the city have seen slight population increases. Garden River, Hilton Beach and Bruce Mines, are among those saw an increase.
- In 2016, 22% of the Sault Ste. Marie population was 65 and over, compared with the provincial rate of 17%. There 16,410 people in Sault Ste. Marie over the age of 65
- The census data also shows that Elliot Lake saw a decline of 5.3 per cent and Blind River a decline of 2.2 per cent.
- Overall, the Algoma District, which includes all communities to the north and south of Sault Ste. Marie saw an overall decrease in population of 1.5 per cent, with the new statistics showing a very slight population of 114,094, down from 115,870 five years ago.
- Most other major cities in Northern Ontario have also experienced a similar population decline. North Bay, Timmins and Thunder Bay, have all seen population declines of similar proportions.
- Sudbury is the only city of the Northern urban centres that saw an increase of a little more than 1,200.

Here is a local breakdown of census population information for communities in the Sault Ste. Marie region:

Community	2016	2011	% change
Sault Ste. Marie	73,368	75,141	-2.4
Blind River	3,472	3,549	-2.2
Mississagi River 8	411	390	5.4
Bruce Mines	582	566	2.8
Thessalon	1,286	1,279	0.5
Elliot Lake	10,741	11,348	-5.3
Hilton Beach	171	145	17.9
Prince	1,010	1,031	-2.0
Macdonald, Meredith and Aberdeen Additional	1,609	1,464	9.9
Laird	1,047	1,057	-0.9
St. Joseph	1,240	1,201	3.2
Wawa	2,905	2,975	-2.4

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External Environment – Summary and Changes to NE LHIN

Summary

The North East Local Health Integration Network (North East LHIN) is one of the largest of 14 LHINs in Ontario, responsible for planning, integrating and funding health care services for more than 565,000 people across an estimated 400,000 square kilometers. From offices across Northeastern Ontario, the NE LHIN is a provincial crown corporation that oversees and funds the local health care system.

The Sault Area Hospital (SAH) is one of 150 of the NE LHIN's health care partners (including 25 hospitals). LHIN partner organizations include hospitals, home and community care, mental health and addictions, community health centres, and long-term care homes.

The NE LHIN Region is made up of 400,000 km2 and 565,000 people. Vibrant and distinct both culturally and linguistically, this region has the highest number of Francophones (at 23% of the population) in the province and a significant number of Aboriginal and First Nation communities (10%).

The NE LHIN has a budget of $1.4 billion in front-line care

Highlights of LHIN Changes

Change in leadership

Louise Paquette, NE LHIN CEO announced that she will be leaving her position as CEO at the end of June 2017.

Kate Fyfe, VP of Performance and Accountability, will assume the responsibilities of Acting CEO while the Board begins the recruitment process.

Changes Related to Home and Community Care

On May 31, 2017, home and community care services and staff transferred from the North East Community Care Access Centre (CCAC) to the North East Local Health Integration Network. Home and community care services are now provided through Ontario's 14 Local Health Integration Networks (LHINs). LHINs plan, integrate and fund local health care. LHINs now deliver and coordinate home and community care. This change was part of the Government of Ontario's Patients First: Action Plan for Health Care.

Development of Sub-Regions

In January 2017, the Ministry of Health and Long-Term Care endorsed five sub-region boundaries proposed by the North East LHIN. A sub-region is a smaller geographic planning region within the North East LHIN that will help better understand and address patient needs at the local level. By looking at care patterns through a smaller, more local lens, the North East LHIN will is able to continue to better identify and respond to community needs and ensure that patients across the entire LHIN have access to the care they need, when and where they need it. This includes the needs of Francophones, Indigenous Northerners, newcomers and other individuals and groups whose health care needs are unique and who often experience challenges accessing and navigating the health care system.

This approach will not restrict Northerners as they make their health care decisions. Sub-regions are not an additional layer of bureaucracy. They are not separate organizations or administrations, and will not have their own staff or boards.

The five North East LHIN sub-regions (which are largely based on the previous planning area HUBS), were established based

on existing care patterns in order to achieve a more local approach to better serve Northerners by ensuring that services reflect the unique needs of patients and communities.

In formalizing our sub-regions, the North East LHIN used the best available evidence, including patient referral patterns and insights from local engagement with patients, providers and community - to ensure that sub-regions align with local needs.

Physicians, nurses, and other clinicians, as well as patients, caregivers and their families will continue to play a key role in planning, priority setting and implementing improvement activities at the sub-region level to ensure the needs of patients and communities are being met.

Geography of NE LHIN

- The NE LHIN is the second largest LHIN with approximately 400,000 square kilometres — 44% of Ontario's land mass.
- Northeastern Ontario is home to approximately 565,000 people.
- Between 1996 and 2011, the population of Northeastern Ontario decreased by 6.1% while the population of Ontario increased by close to 21%1.
- Between 2014 and 2036, the population of Northeastern Ontario is projected to decrease by less than 1%, while Ontario is expected to increase by 26%5
- The proportion of the population age 65 and over is projected to increase from 19% to 30% by 2036, a projected increase of 55%5.

Key Population Health Characteristics for NE LHIN

Relative to the provincial average (based on 2013 Statistics Canada Health Profile), the NE LHIN has a higher number of people who:

- are overweight or obese
- have high blood pressure
- have diabetes
- have arthritis
- have chronic obstructive pulmonary disease (COPD)
- smoke daily
- are heavy drinkers
- have a mood disorder

Life Expectancy in NE LHIN

In the NE LHIN region, life expectancy for both males and females is below the provincial average according to the 2016 Census. Females are expected to live until 81.4 versus the provincial 83.6. Males are expected to live to 76.5 versus the provincial 79.2.

Life Expectancy in Ontario, 1976 to 2036

		1976	1986	1996	2006	2016	2026	2036
Male	At birth	70.8	73.7	75.9	78.8	81.3	83.4	85.3
	At age 65	13.9	15.0	16.1	18.4	19.7	21.2	22.5
Female	At birth	78.0	80.0	81.3	83.1	84.9	86.4	87.8
	At age 65	18.2	19.1	19.9	21.3	22.2	23.3	24.3

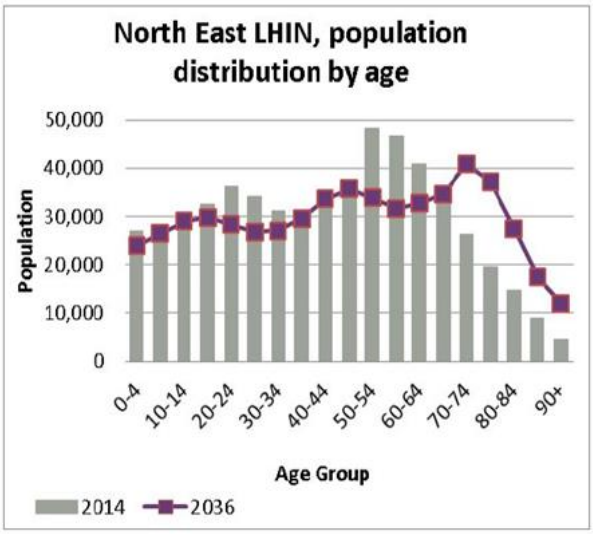
Sources: Statistics Canada, 1976–2006, and Ontario Ministry of Finance projections.

According to 2011 Census (note: breakdown of specific 2016 stats not available yet)

- During the 2011/2012 fiscal year, there were 5,155 births to 4,966 women in NE LHIN hospitals. 8.3% of women who gave birth were age <20 (much higher than the provincial proportion of 3.2%). The proportion of births to women >=35 is the lowest in the province.
- In the NE LHIN region, over 1 in 4 women smoked during their pregnancy (the second highest rate among LHINs). The rates of breastfeeding initiation and caesarean delivers were similar to the provincial rate.
- The rate of pre-term and 'small for gestational age' newborns was lower than the provincial rate, whereas the percentage classified as 'large for gestational age' was higher than the provincial rate (and was the second highest rate among LHINs).
- NE LHIN residents had the second lowest life expectancy at birth and the lowest life expectancy at age 65 (compared to other LHIN areas). Overall mortality rates were the second highest in the province, and mortality rates in the 0-19, 20-44, 45-64 and 65-74 age groups were the highest in the province as well.
- PYLL rates in the NE and North West LHINs are double that of rates in the lowest LHINs (Mississauga Halton and Central). In the NE LHIN, there were twice as many deaths per 100,000 for those aged 45-64 compared to the Central LHIN.
- 42.7% of NE LHIN residents died before the age of 75; higher than the provincial proportion of 37.2%.
- The leading causes of death in Ontario were Ischaemic heart disease, cancer of lung/bronchus, and dementia and Alzheimer disease. In 2011, in the NE LHIN, Ischaemic heart disease, lung cancer, cancer of colon, rectum, and anus, cancer of lymph, blood and related, and diabetes were leading causes of death and PYLL. The top 10 leading causes of death accounted for 55.1% of deaths.
- Mortality rates for many causes including heart disease, cancers, chronic respiratory disease, and diabetes were the highest in the province.
- PYLL rates for transport accidents were the highest in the province, and PYLL rates for intentional self-harm were the second highest in the province.
- Injury-related deaths (transport accidents, intentional self-harm and accidental poisoning) were in the top 10 leading causes of PYLL in the NE LHIN. Together, these accounted for 1,007.2 PYLL for every 100,000 residents (higher than the PYLL rate of 655.6/100,000 for Ischaemic heart disease, which was the single leading cause of death in the NE LHIN).

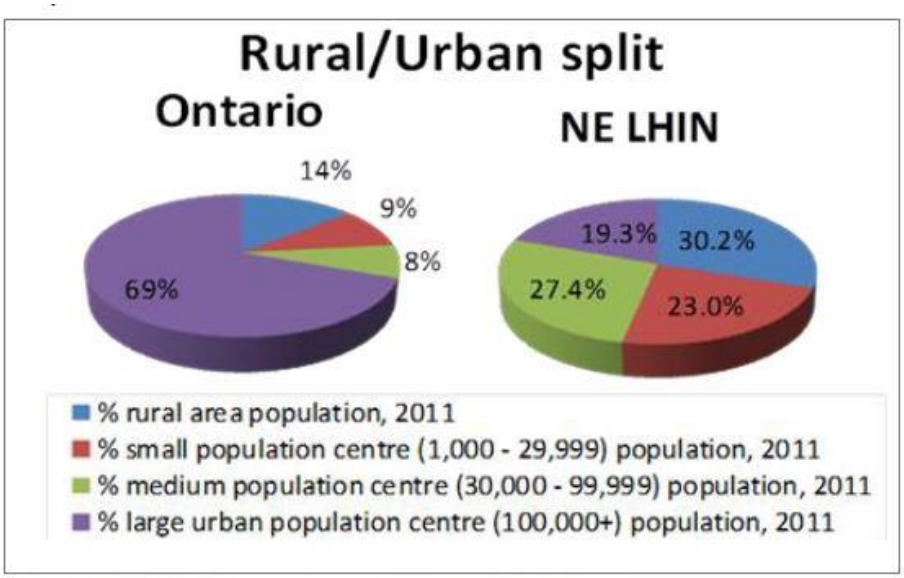
Aging population

- The population in the NE LHIN population is projected to change dramatically over the next 22 years.
- The Ministry of Finance projects a 1% overall population decline expected by 2036 and proportion of the population age 65 and over projected to increase from 19% to 30%.



Rurality

- Approximately 19% of people living in Northeastern Ontario live in an urban centre, compared to about 69% in Ontario.
- Twice as many people in Northeastern Ontario live in rural areas (30%) compared to 14% in Ontario.



*based on data from the Statistics Canada 2011 Population Census.[1]

Diversity

- High proportion of Francophone population at 23%, with only 5% of that in the Algoma sub-region.
- Aboriginal, First Nations and Métis people account for approximately 11% of the Ontario population.
- Indigenous peoples make up 11,730 of the 102,000 population of the Algoma SUB-LHIN.

Patients First – Five Key Components

1. Expanded Role for LHINs
    a. LHINs are responsible for all health service planning and performance.
    b. Sub-regions as focal point for integrated service planning and delivery.
2. Timely Access to, and Better Integration of, Primary Care
    a. LHINs are responsible for primary care planning and performance improvement, in partnership with local clinical leaders.
3. More Consistent and Accessible Home & Community Care
    a. Direct responsibility for service management transferred from CCACs to LHINs.
4. Stronger Links to Population & Public Health
    a. Formalized linkages between LHINs and public health units.
5. Improving Health Equity and Reducing Health Disparities
    a. Indigenous, Franco-Ontarians and other cultural groups.

Expanded Role for LHINs

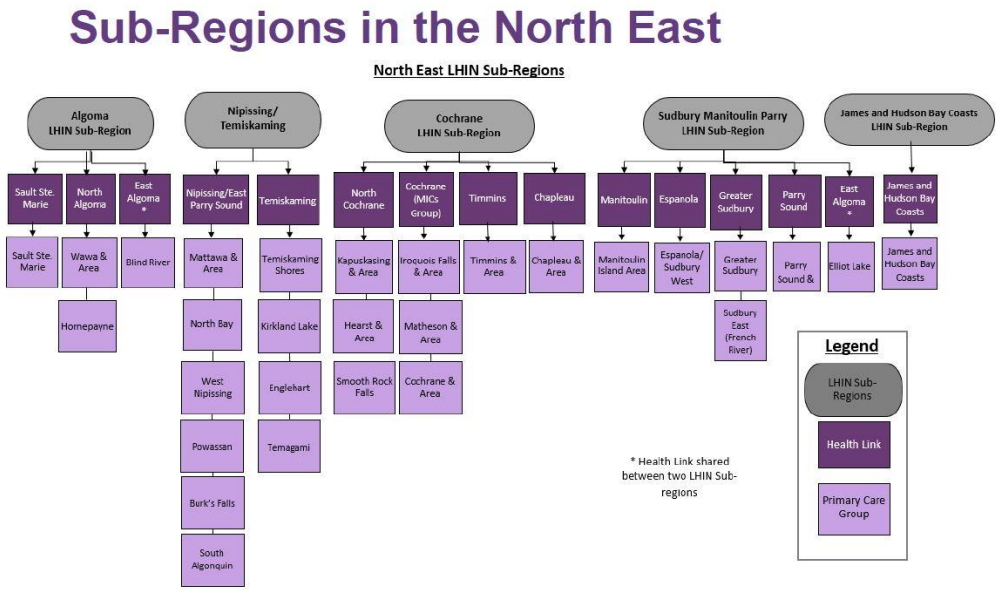
- LHINs are responsible for all health service planning and performance.
- Sub-regions serve as a focal point for integrated service planning and delivery.

Source: North East LHIN. Implementing Patients First in the North East LHIN: Focus in Year One (Presentation to Health Care Providers May 24, 2017)

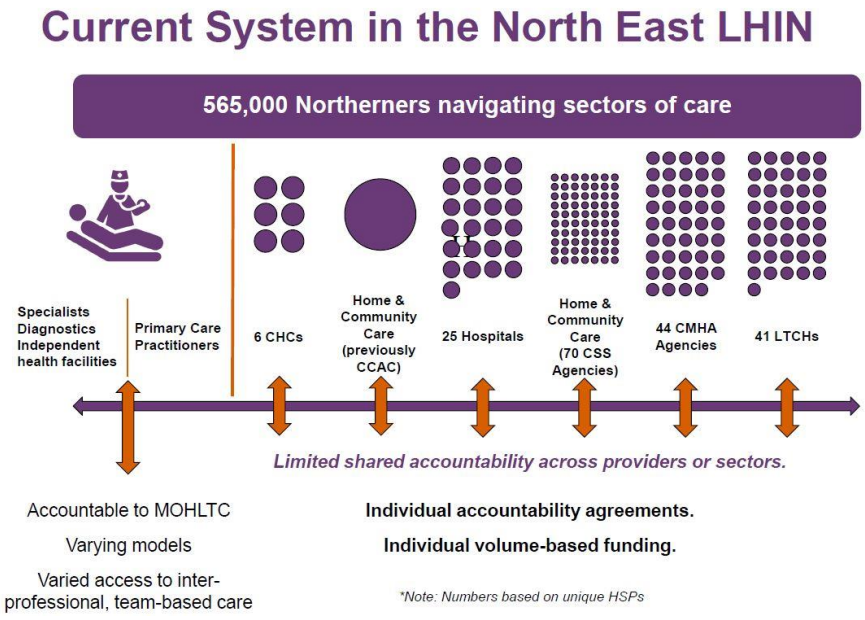
Development of Sub-Regions

- Are smaller geographic units created to better address and understand patient needs at the local level.
- Take into account the diverse geographic, population and demographic needs to deliver quality care in an effective and efficient manner, including to Francophone and Indigenous people.
- Are based on existing care patterns, using the best available evidence, including engagement with patients, providers and community members.
- Will support physicians, nurses, and other clinicians, as well as patients, caregivers and their families playing a role in planning, priority setting and implementing improvement activities.

- Are NOT service boundaries –patients will continue to have their choice of where to receive services within and outside of the sub-region.
- Are NOT an additional bureaucratic layer in health care service delivery. They are simply a better way for the NE LHIN to plan and improve health services in a manner that is more in line with the diverse needs of communities across this vast region.
- About optimizing existing funding and making recommendations to the LHIN about priorities and future funding.



Source: North East LHIN. Implementing Patients First in the North East LHIN: Focus in Year One (Presentation to Health Care Providers May 24, 2017)



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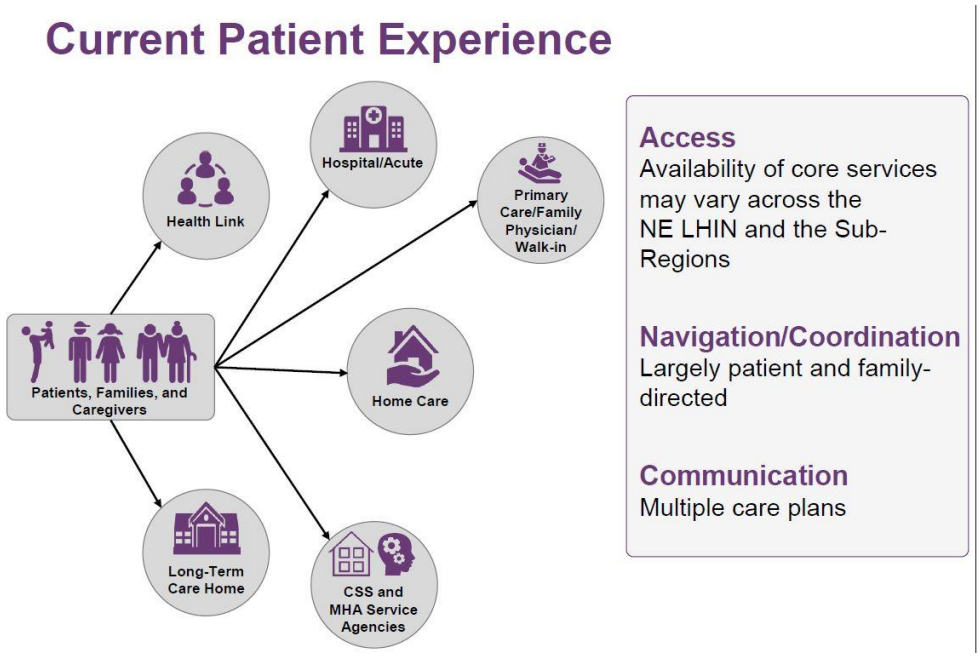
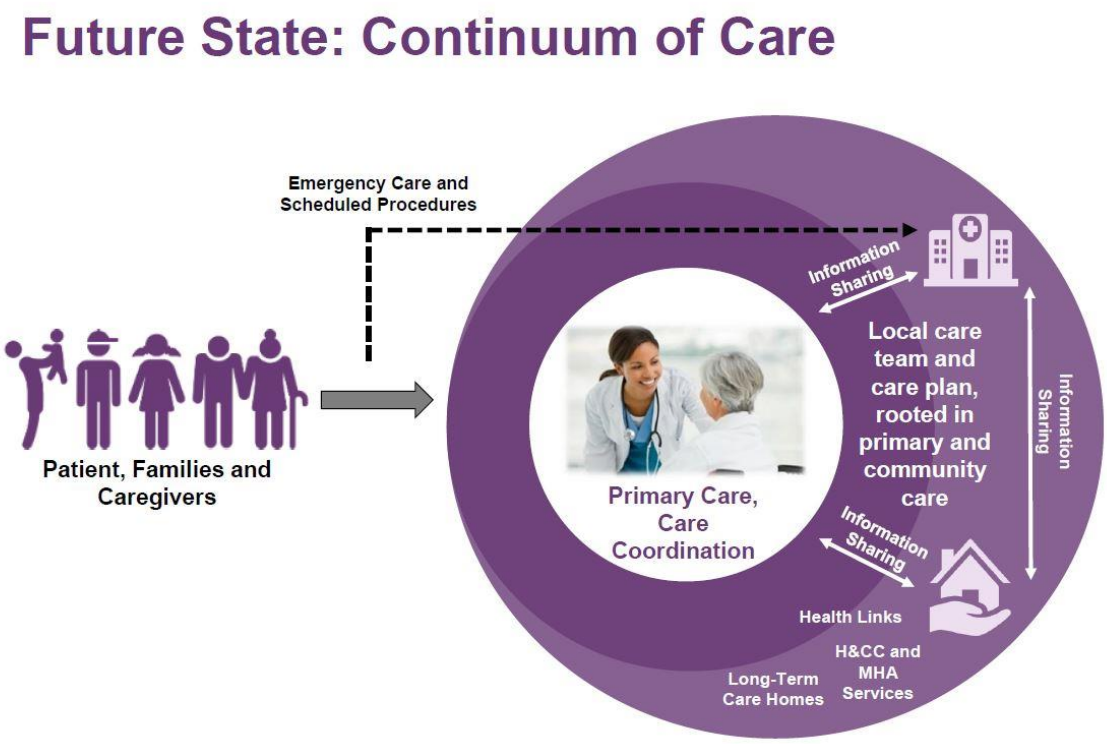


Source: North East LHIN. Implementing Patients First in the North East LHIN: Focus in Year One (Presentation to Health Care Providers May 24, 2017)



Source: North East LHIN. Implementing Patients First in the North East LHIN: Focus in Year One (Presentation to Health Care Providers May 24, 2017)

Opportunities NE LHIN has identified

•Awareness of, and access to, services in the community is a challenge.

•Opportunities exist for primary care services to be strengthened and integrated in the community.

•People are assessed over and over –and need to tell their story to each new provider.

•We need to focus on a few impactful priorities and avoid "trying to boil the ocean."

NE-LHIN Algoma Sub-Region Goal for Year 1

Delivering Home & Community Care and Primary Care to better serve and support patients and their caregivers at the local level to:

- Help you, your family, friends and neighbours will have greater access to primary care and home and community care.
- Strategies will be implemented to prevent premature:
    - Visits to emergency departments
    - Admissions to hospital
    - Admissions to long-term care homes.
- Ensure primary care will be better supported by care coordination services.
- Ensure people will have smoother transitions across the continuum of care and have improved experiences.
- Ensure people will be better supported to live safely at home.

LHINs responsible for primary care planning and performance improvement, in partnership with local clinical leaders.

Primary Care Clinical Leads:

• NE LHIN/ Nipissing-Temiskaming: Dr. Paul Preston

• Sudbury-Manitoulin-Parry Sound: Dr. Jason Sutherland

• Cochrane: Dr. Yves Raymond

• Algoma: Dr. Dave Fera and Dr. Jodie Stewart

NE LHIN Sub-Region Algoma`s Primary Care Strategy Overview

•Primary care is a patient's medical home, and entryway to both community services and specialty services. We need to strengthen primary care's ability to play this role for all patients, including complex patients.

•We need to work with and listen to primary care providers to determine how best to support communities and strengthen primary care to be the patient's medical home.

•We will plan for 26 Primary Care Groups, which are communities/neighborhoods where primary care providers work together to support 100% of patients.

•Clinical Leads will support our primary care physicians, NPs and organizations to build plans to overcome local issues.

Primary Care Priorities for 2017/18

Continue to build primary care as the foundation of the health care system to develop sub-region plans that:

- Use an equity lens to assess the number and proportion of primary care providers based on the needs of the local population.
- Improve access to primary care providers including family doctors and nurse practitioners.
- Facilitate effective and seamless transitions.
- Improve access to inter-professional health care providers.
- Implement a plan that embeds care coordinators and system navigators in primary care to ensure smooth transitions.
- Support integration of Health Links into sub-regional planning.

Home and Community Care Priorities

With input from patients, caregivers and partners:

- Reduce wait times and improve coordination and consistency of home and community care so that clients and caregivers know what to expect.
- Continue to implement the initiatives in Patients First: A Roadmap to Strengthen Home and Community Care.

A key priority for 2017-18 is the completion and consolidation of the transition.

NE LHIN - Our Common Focus

•Primary Care

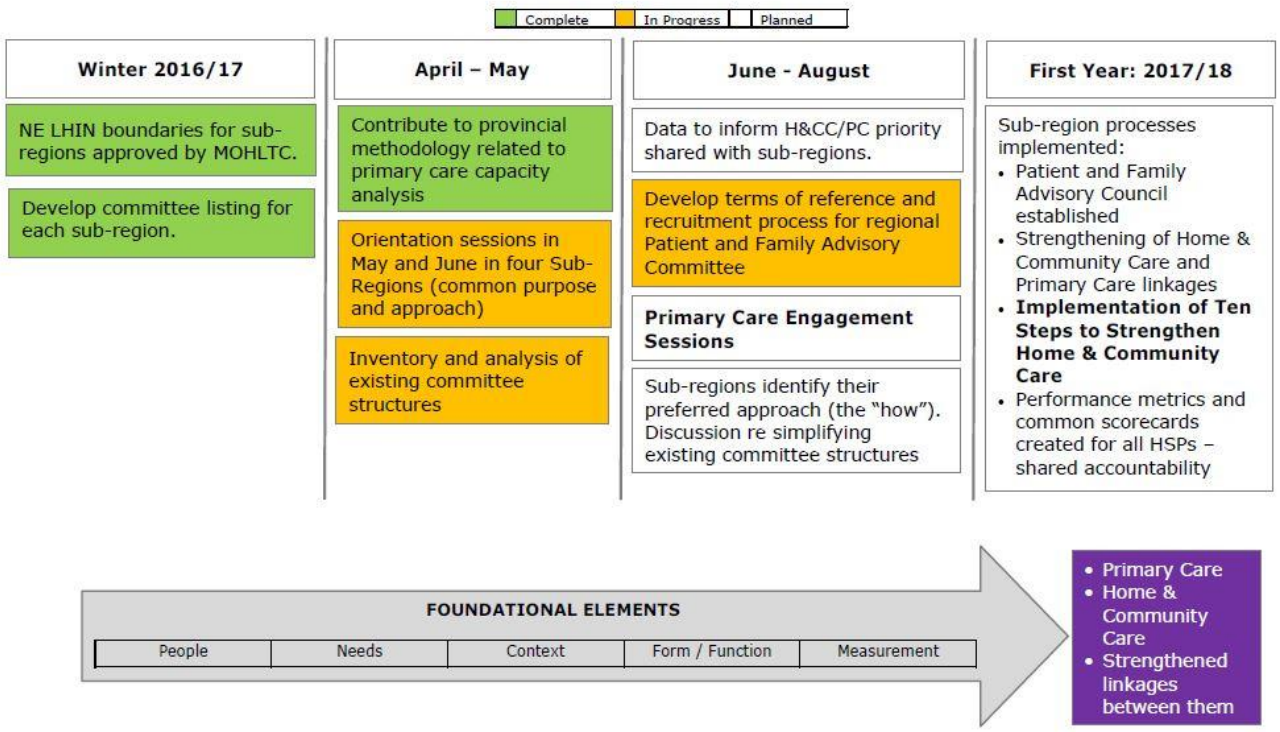
•Home & Community Care Services

•Strengthening linkages between them

•This may involve aligning or leveraging existing structures.

•As per the Patients First Act, each Sub-Region will develop a Strategic Plan.

•This is a start and our initial focus for the next 12 months.



Source: North East LHIN. Implementing Patients First in the North East LHIN: Focus in Year One (Presentation to Health Care Providers May 24, 2017)

Local Health Integration Network strategic priorities

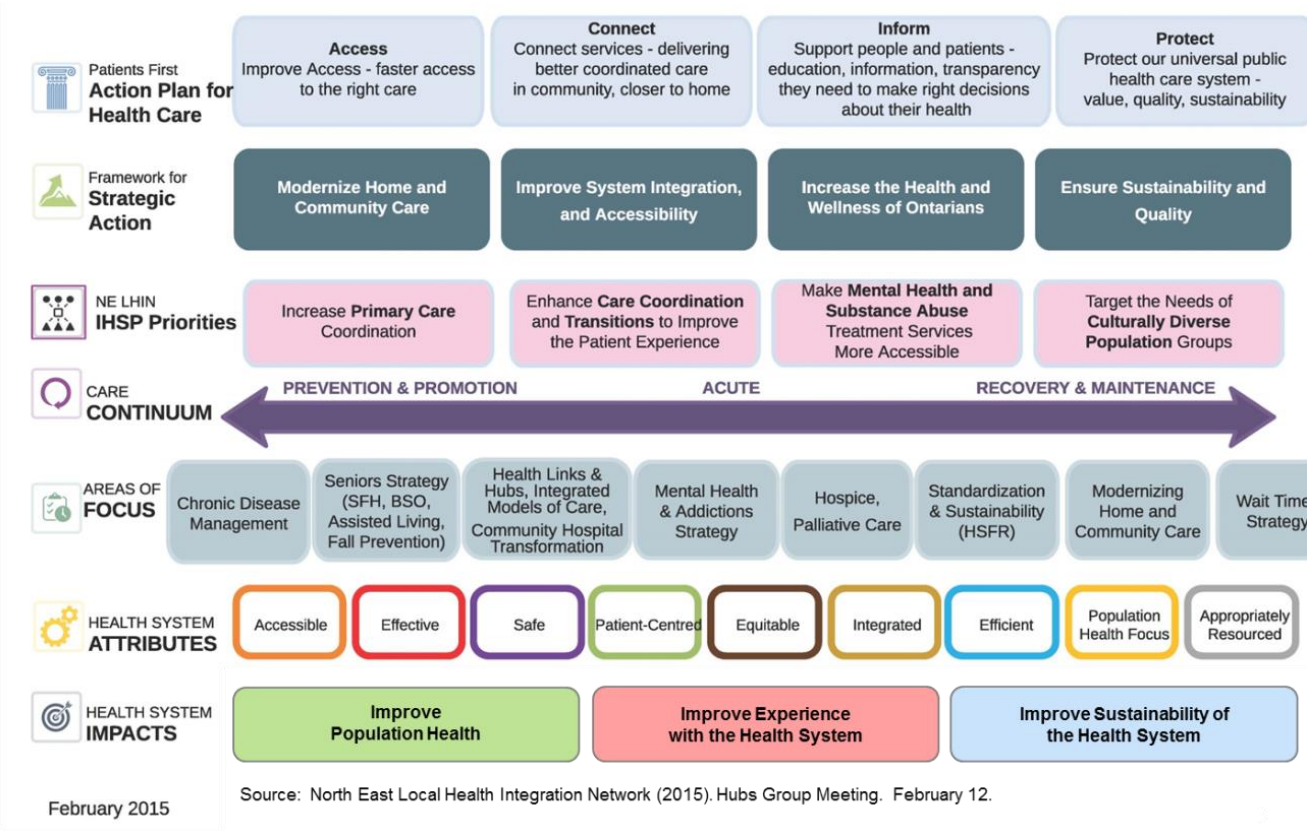
- The NE LHIN has begun developing its next three year strategic plan for the period 2016 to 2019. In November/December 2014, the NE LHIN sought input from Northerners via a survey on how the home and community based system of care can be strengthened across the NE LHIN region. One thousand and nine (1009) Northerners responded. Six key themes emerged from the responses received:
  1. Access to a variety of services necessary to allow residents to receive the care they need in their homes and communities;
  2. Funding and accountability with regard to better efficiency and value-for-money, as well as improved measures for accountability for results;
  3. Coordination and integration among the various care providers, including the desire for one point of access for primary health care services;
  4. Increased health human resources across a variety of allied health providers including registered nurses, nurse practitioners and personal support workers;
  5. Communication, education and engagement; and
  6. Cultural diversity and Northern perspective particularly addressing the specific needs to two key groups – Francophones and Aboriginals.
- Public engagement sessions began in April and concluded in September.
- SAH is participating in a NE LHIN-wide effort to develop a high-user report.

- The NE LHIN is focusing on Northerners' housing needs. A new Northeastern Ontario expert panel will focus on the housing and support needs of the frail elderly, the homeless and at-risk populations, and people with mental illness and addiction issues.
    - The NE LHIN has engaged the Northern Ontario Service Deliverers Association (NOSDA) to assist in the development of an innovated housing and health strategy. The NOSDA is an incorporated body that brings together service managers in the North East region who are responsible for the planning, coordination, and delivery of a range of community services including social housing.
    - The strategy will include an inventory of supportive housing across the region, identify perceived barriers, opportunities, capacity issues and gaps, examine support needs for vulnerable populations, and gather best practices
    - The strategy will be presented to the NE LHIN Board in the fall of 2016
    - On February 18, 2016, SAH participated in the first Point-in-Time homeless count in collaboration with the Homelessness Partnering Strategy. It will identify how many people in the community experience homelessness in shelters and on the streets and will gather demographic and service needs which can be used to target community resources to where they are needed most.

Source: North East LHIN. http://www.nelhin.on.ca/strategicplan.aspx

LHIN Provincial Strategic Framework

A snapshot of Health System Priorities for Ontario and Northeastern Ontario



Algoma Sub-Region Demographics

Every year the NE LHIN provides $257 million to 29 health service providers who deliver programs and services to 102,000 people living in the Algoma Sub-Region. In addition to LHIN-funded providers, the NE LHIN works with health care and community partners to increase access to care.

Sub-Region Demographic Highlights (based on 2011 Census survey results)

- Similar proportion of seniors living alone (28.1%) compared to the LHIN (28.4%).
- Slightly higher proportion of lone parent families (17.5%) compared to the LHIN (16.2%).
- Significantly lower proportion of Francophones (7.1%) compared to the LHIN (23.4%).
- Higher proportion of seniors 65 and older (21%) compared to the LHIN (19.8%).
- Slightly lower proportion of youth under 25 (26.2%) compared to the LHIN (26.7%).
- Similar proportion of people identifying as Indigenous (11.5%) compared to the LHIN (11.0%).
- Slightly higher proportion of population having low income (14.2%) compared to the LHIN (13.9%).
- Similar proportion of population having higher education (50.1%) compared to the LHIN (50.4%).
- Sub-Region Health Service Provider Overview
- 4 hospitals, 323 beds (including mental health beds)
- 17 home and community care providers (5 regional), 2,000+ receiving personal support services
- 77 primary care practitioners, 4 FHTs, 2 NPLC, 1 AHAC, 1 GHC, 3 nursing stations
- 9 mental health and addictions providers, plus 2 hospitals providing services
- 7 long-term care homes, 1,048 beds
- 1 public health unit – Algoma Public Health

The Local Health System Integration Act

The legislation gives the LHINs the legislative power and authority they will need to effectively plan, coordinate, and fund their local health systems to make it easier for patients to access the care they need.

General health and risk factors

- In the Canadian Community Health Survey 2010-2011, 57% of NE LHIN residents said they have very good or excellent health, and 73% reported very good or excellent mental health. These rates were lower than most LHIN areas.
- Approximately 19% of NE LHIN residents said they usually experience moderate or severe pain/discomfort, and 37% said they experience activity limitations because of long-term physical or mental health problems. These rates were higher than most other LHIN areas, and significantly higher than the provincial average.
- 21% of NE LHIN residents reported that most days were 'quite a bit' or 'extremely' stressful, similar to the provincial rate (24%) but among the lowest compared to other LHIN areas.
- The NE LHIN has 538 family physicians, one Group Health Centre in Sault Ste. Marie (about 80 general and specialty physicians), 27 Family Health Teams, six Community Health Centres, six Nurse Practitioner-Led Clinics, 16 Nursing Stations and three Aboriginal Health Access Centres.
- 37% of NE LHIN residents received a flu shot in the past year. This is significantly higher than the provincial average, but over time the proportion of residents getting a flu shot has declined.
- The prevalence of physical inactivity (43%) in the NE LHIN was significantly lower than the provincial average of 45.6%.
- Approximately three out of five residents reported inadequate consumption of fruits and vegetables (consume fewer than five servings daily). This is similar to provincial findings.

Chronic conditions (based on 2011 Census results)

- One in three Ontarians has at least one chronic disease. Among those aged 65 and over, 80% have at least one chronic disease, and, of these, 70% have two or more chronic diseases.
- In 2013, 43% of NE LHIN residents (aged 12+) had a chronic condition and 21% had multiple conditions. The prevalence of multiple chronic conditions amongst NE LHIN residents was significantly higher in comparison to the province and the highest among LHINs.
- Prevalence of multiple chronic conditions increased dramatically with age. 52% of NE LHIN residents aged 65-74 and 61% of residents aged 75+ had two or more chronic conditions.
- Approximately one in four in the NE LHIN suffered from arthritis, and the prevalence of COPD was almost twice that of the province. The prevalence of arthritis, COPD, high blood pressure and heart disease was significantly higher in the NE LHIN compared to Ontario. It is also noteworthy that the NE LHIN had the highest prevalence among LHINs for two of the eight conditions examined which is a decrease from 2010 in which the NE LHIN had six of eight. In addition, prevalence rates for COPD and asthma declined while the rate of diabetes increased since 2009-2010.
- Chronic conditions accounted for almost 2 out of 3 deaths, 1 out of 4 acute hospital separations, and 3 out of 10 acute hospital days for NE LHIN residents.
- Mortality and hospitalization rates for all chronic conditions (except asthma mortality) were notably higher than provincial rates.
- Heart disease (including ischemic heart disease (IHD) and congestive heart failure (CHF) and stroke accounted for 11% of all hospital days and 10% of all acute care separations in the NE LHIN. One in 5 residents aged 65-74 had heart disease. The prevalence increased to 30% among those aged 75+.
- Approximately 9% of NE LHIN residents suffered from asthma and 7% had COPD. These chronic respiratory conditions accounted for approximately 4% of hospital days among LHIN residents.

- Many chronic conditions can be prevented or onset can be delayed. Smoking, misuse of alcohol, excess weight, poor diet and physical inactivity are well-established modifiable risk factors for many chronic conditions. Over 80% of COPD, for example, is attributable to smoking and 50% of diabetes is attributable to obesity.

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External Environment – Political terrain, government mandate and regional strategic initiatives

The provincial health care system continues to transform with key focuses on access, integrated services, information and transparency, and sustainability.

National and Provincial political environment

- Prime Minister Justin Trudeau was sworn in on November 4, 2015 after the Liberal Party of Canada won a majority government in the October 19, 2015 Canadian federal election. The Honourable Jane Philpott (Markham-Stouffville) was appointed to Cabinet as Minister of Health.
- In June 2014, The Honourable Eric Hoskins was appointed Minister of Health & Long-Term Care. He previously served as Minister of Economic Development, Trade and Employment and Minister of Children and Youth Services.
- Kathleen Wynne was sworn in as Premier of Ontario on February 11, 2013, becoming the province's first female Premier

Sault Ste. Marie political environment

- Long-time Member of Provincial Parliament David Orazietti resigned from cabinet on December 16, 2016, effective January 1, 2017.
- During Orazietti's tenure, he brought forward several Private member bills to improve such things as the Northern Health Travel Grant.
- On February 11, 2013, Orazietti was appointed to cabinet as Minister of Natural Resources.
- On June 24, 2014, Wynne appointed him to a second ministry, this time as Minister of Government and Consumer Services.
- On June 13, 2016, Wynne appointed Orazietti as Minister of Community Safety and Correctional Services.
- After Orazietti's resignation, there was a provincial by-election for the seat in Sault Ste. Marie.
- Local city counsellor Ross Romano ran a successful campaign for the Progressive Conservatives winning the provincial by-election in Sault Ste. Marie, securing the party's first victory in the Northern Ontario riding since 1981. The victory didn't change the balance of power in the legislature.

Health Canada's Regulatory Transparency and Openness Framework

- In April 2014, the Honourable Rona Ambrose, Minister of Health, announced the Regulatory Transparency and Openness Framework. This Framework is Health Canada's plan for improving access to timely, useful and relevant health and safety information for Canadians. Key achievements in 2014/2015 include:
    - Over 35 safety reviews have been posted on Health Canada's website;
    - The Drug and Health Product Register was created which is a new tool designed to become the go-to resource for Canadians looking for quick access for information on hundreds of prescription drugs; and
    - Consultation with Canadians on how to improve nutritional information on food labels.
- In June 2015, Minister Ambrose announced the next phase of Health Canada's Framework – a three-year plan for the period 2015-2018. Key commitments include expanding the information available in the Drug and Health Product Register to include a wider variety of products and information, and enhancing the Drug and Health Product Inspection Database to include more information on Health Canada inspection activities.

Source: Health Canada (2015). Regulatory Transparency and Openness Framework and Action Plan 2015-2018. http://www.hc-sc.gc.ca/home-accueil/alt_formats/pdf/rto-tor/2015-18-fap-cpa-eng.pdf

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SAH CEO Management Report June 2017

External Environment – Legislation, regulation & policy reform

Legislative and regulatory amendments increase focus on resolving concerns raised by patients and their caregivers, introduce Ontario's first Patient Ombudsman, and enhance patient safety and transparency.

Discussion

Recent legislative and regulatory changes increase the focus on patients and include improvements to the existing patient relations process as well as the introduction of a provincial Patient Ombudsman. Changes also increase patient safety regarding drugs, and a review of legislation that protects information calls for increased transparency.

Highlights

Excellent Care for All Act, 2010

- The Excellent Care for All Act (ECFAA), which came into force in June 2010, requires health care organizations to:
    - Establish quality committees that report on quality-related issues;
    - Develop annual quality improvement plans and make them available to the public;
    - Implement patient and employee satisfaction surveys;
    - Establish a patient relations process to address and improve the patient experience;
    - Link executive compensation to achievement of quality plan performance improvement targets; and
    - Develop declarations of values after public consultation.
- In December 2014, Bill 8 (Public Sector and MPP Accountability and Transparency Act, 2014) received Royal Assent. This Bill amends the ECFAA to introduce a Patient Ombudsman.
- On December 10, 2015, the MOHLTC announced that Christine Elliott was selected as Ontario's first-ever Patient Ombudsman. The Patient Ombudsman will help patients and family members who have unresolved complaints about their care at a hospital, long-term care home or Community Care Access Centre. This Ombudsman will help ensure that health care in Ontario is continuing to focus on patients' needs first and will help in reaching a satisfactory resolution. The Ombudsman is expected to make recommendations about how to prevent recurrence of such complaints and will be housed in Health Quality Ontario.
- Elliot's appointment came into effect July 1, 2016. Preliminary work began in early 2016.
- To support the commitment to patients first and Ontario's Action Plan for Health Care, two new regulations under the ECFAA became effective September 1, 2015:
    - Regulation 188/15 on the Patient Relations Process – requires hospitals to engage patients and their caregivers in development of the patient relations process, specifies data that must be collected as part of the patient relations process, prescribes that concerns must be acknowledged within 5 calendar days, requires the designation of a patient relations process delegate, and requires that person to present aggregate patient relations data to the hospital's quality committee at least twice a year; and
    - Regulation 187/15 on the Annual Quality Improvement Process (QIP) – prescribes that health care organizations must engage patients and their caregivers in the development of annual QIPs and that QIPs must include a description of patient engagement activities.
- March 2017, there was a proposal to amend Ontario Regulation 445/10 made under the *Excellent Care for All Act, 2010* (ECFAA or the "Act") to support amendments made to ECFAA by the *Patients First Act, 2016* (PFA) related to the Ontario Health Quality Council (operating as Health Quality Ontario) and other housekeeping changes

- The ministry is proposing to amend Ontario Regulation 445/10 made under ECFAA (the "Regulation") to address certain amendments made to ECFAA by the PFA. If approved by the Lieutenant Governor in Council ("LGIC"), most of the Regulation amendments would take effect at the same time that the ECFAA amendments effected by subsections 37(3), (4) and (5) of the PFA are proclaimed into force on May 1, 2017 (the "ECFAA Amendments"). The purpose of the ECFAA Amendments was to make the statutory changes necessary to confer authority on HQO to retain assets and revenues outside of the Province's consolidated revenue fund. The text of the proposed Regulation amendments are:
    - Delete provisions in the Regulation relating to the corporate status and powers of Health Quality Ontario (HQO) which, pursuant to the ECFAA Amendments, have been moved into the Act [s.3(1), 4, 7, 9 of the current Regulation];
    - Make the following housekeeping changes:
        - Delete and amend outdated provisions in the Regulation relating to sections of the Act that were previously repealed [s.3(4) and (4) of the current Regulation]
        - Provide for the substitution of the reference to the *Corporations Act* in section 5 of the Regulation with a reference to the *Not-for-Profit Corporations Act, 2010* (NFPCA), once the NFPCA is proclaimed into force.

The Protecting Canadians from Unsafe Drugs Act (Vanessa's Law)

- Vanessa's Law received Royal Assent in November 2014. The legislation introduces significant improvements to drug safety in Canada. It enables Government to recall unsafe products, improve new penalties for unsafe products including jail time and new fines of up to $5 million per day instead of the current $5,000, compel drug companies to do further testing and revise labels to clearly reflect health risk information in plain language, enhance surveillance by requiring mandatory adverse drug reaction reporting by health care institutions, and require new transparency for Health Canada's regulatory decisions about drug authorizations.
- The Law is named after Member of Parliament Terence Young's daughter Vanessa who died of a heart attack while on a prescription drug that later was deemed not safe and removed from the market.
- The following new powers came into force immediately upon Royal Assent:
    - Ability to recall unsafe therapeutic products;
    - Ability to impose tougher fines and penalties;
    - Ability to direct label change/modification; and
    - Ability to seek an injunction.
- Health Canada has launched two new initiatives related to Vanessa's Law:
    - Consultations asking Canadians and health care stakeholders about the types of drug safety information they are looking for when making informed health decisions and conducting health safety research; and
    - Guide to New Authorities that sets out for industry, researchers and the public the principles, policy and standards that Health Canada will follow when using key new powers.
- In April 2017, Health Canada proposed new regulations that would allow it to identify, assess and respond more quickly and effectively to safety issues that emerge after a drug comes on the market.
- Under these proposed regulations, Health Canada would be able to require companies to conduct new tests or studies, or to compile new information and report back to the Department.
- Companies will also be required to notify Health Canada of any actions requested or required by a regulator in another jurisdiction such as risk communications, label changes, recalls, or license suspensions. Failure to comply could result in companies being subject to increased fines and penalties which have already come into force under Vanessa's Law.

Marijuana for Medical Treatment

- There have been a number of recent developments regarding the use of marijuana for medical treatment purposes including:
    - A decision from the Supreme Court of Canada on the permissible forms in which medical marijuana may be dispensed and used;
    - Legislative changes to the Narcotic Control Regulations and the Marijuana for Medical Purposes Regulations regarding reporting to applicable provincial regulatory colleges; and
    - New penalties under the Controlled Drugs and Substances Act for non-compliance issues, including reporting and security-related requirements.
- In R v. Smith, the applicant alleged that restricting lawful possession of medical marijuana to dried forms deprived individuals of the freedom to choose how to administer the medication and violated section 7 of the Canadian Charter of Rights and Freedoms. The Supreme Court of Canada upheld the applicant's Charter challenge. The Court's decision expands the permissible forms in which one is entitled to lawfully possess medical marijuana but does not change the regime for obtaining lawful access to medical marijuana.
- Under the Narcotic Control Regulations, hospitals are subject to record-keeping and security-related requirements regarding controlled substances (narcotics). The provisions require that hospitals maintain records of controlled substances received and dispensed, and take all necessary steps to protect controlled substances in the hospital against loss or theft. This Regulation also outlines hospitals' obligations in relation to administration and/or provision of medical marijuana.
- The decision in R. v. Parker in 2000 held that individuals with a medical need had the right to possess marijuana for medical purposes.
- This led to the implementation of the Marihuana Medical Access Regulations (MMAR) in 2001. The MMAR enabled individuals with the authorization of their health care practitioner to access dried marijuana for medical purposes by producing their own marijuana plants, designating someone to produce for them or purchasing Health Canada supply.
- In June 2013, the Government of Canada implemented the Marihuana for Medical Purposes Regulations (MMPR). The MMPR created conditions for a commercial industry responsible for the production and distribution of marijuana for medical purposes.
- In June 2015, the Supreme Court of Canada decided that restricting legal access to only dried marijuana was unconstitutional and that individuals with a medical need have the right to use and make other cannabis products.
- To eliminate uncertainty around a legal source of supply of cannabis, the Minister of Health issued section 56 class exemptions under the CDSA in July 2015, to allow, among other things, licensed producers to produce and sell cannabis oil and fresh marijuana buds and leaves in addition to dried marijuana, and to allow authorized users to possess and alter different forms of cannabis.
- The ACMPR is Canada's response to the Federal Court of Canada's February 2016 decision in Allard v. Canada. This decision found that requiring individuals to get their marijuana only from licensed producers violated liberty and security rights protected by section 7 of the Canadian Charter of Rights and Freedoms. The Court found that individuals who require marijuana for medical purposes did not have "reasonable access".
- The ACMPR are designed to provide an immediate solution required to address the Court judgement. Moving forward, Health Canada will evaluate how a system of medical access to cannabis should function alongside the Government's commitment to legalize, strictly regulate and restrict access to marijuana.

- Overall, the ACMPR contain four parts.
    - Part 1 is similar to the framework under the MMPR. It sets out a framework for commercial production by licensed producers responsible for the production and distribution of quality-controlled fresh or dried marijuana or cannabis oil or starting materials (i.e., marijuana seeds and plants) in secure and sanitary conditions.
    - Part 2 is similar to the former MMAR regime. It sets out provisions for individuals to produce a limited amount of cannabis for their own medical purposes or to designate someone to produce it for them.
    - Parts 3 and 4 include:
        - Transitional provisions, which mainly relate to the continuation of MMPR activities by licensed producers

- Consequential amendments to other regulations that referenced the MMPR (i.e., Narcotic Control Regulations, New Classes of Practitioners Regulations) to update definitions and broaden the scope of products beyond dried marijuana
- As of August 24, 2016, the Access to Cannabis for Medical Purposes Regulation (ACMPR) will replace the Marihuana for Medical Purposes Regulations (MMPR).

- As of August 24, 2016, Health Canada will accept applications from individuals who wish to register to produce a limited amount of cannabis for their own medical purposes or to designate someone to produce cannabis for them.
- Under the ACMPR, Health Canada will continue to accept and process applications to become a licensed producer that were submitted under the former MMPR. Further, all licenses and security clearances granted under the MMPR will continue under the ACMPR, which means that licensed producers can continue to register and supply clients with cannabis for medical purposes. New applicants can continue to apply for licenses to produce under the ACMPR
- As with the previous regulations, an individual who requires cannabis for medical purposes must first get a medical document from an authorized health care practitioner. Like under the MMPR, the medical document contains similar information to a prescription, including:
    - the authorized health care practitioner's license information
    - the patient's name and date of birth
    - a period of use of up to one (1) year
    - a daily quantity of dried marijuana expressed in grams
- In a hospital setting, the person in charge of the hospital can allow fresh or dried marijuana or cannabis oil to be administered to a patient or, sold or provided to a patient or an individual responsible for the patient.

Bill 119, Health Information Protection Act, 2015

- On September 16, 2015, the Minister of Health & Long-Term Care (the Minister) introduced Bill 119, Health Information Protection Act, 2015 which would improve privacy, accountability, and transparency in health care.
- Some of the changes under Bill 119 would include:
    - Making it mandatory to report privacy breaches to the Information and Privacy Commissioner, and to relevant regulatory colleges; and
    - Doubling the maximum fines for offences from $50,000 to $100,000 for individuals and from $250,000 to $500,000 for organizations.
    - Adding a new component regarding Electronic Health Records
- The legislation would also amend the Quality of Care Information Protection Act, 2004 (QCIPA) to help increase transparency and maintain quality in Ontario's health care system including the following:
    - Affirming the rights of patients to access information about their own health care;
    - Clarifying that certain information and facts about critical incidents cannot be withheld from affected patients and their families; and
    - Requiring the Minister to review QCIPA every five years.

- Amendments to the Personal Health Information Protection Act (PHIPA,) were introduced September 16, 2015 and proclaimed in May 2016 to enhance the protection of personal health information.

Medical Assisted Dying (MAID)

- On February 6, 2015, the Supreme Court of Canada's decision in Carter v. Canada held that sections 241(b) and 14 of the Criminal Code violate the constitutional rights of certain grievously and irremediably ill adult individuals. These sections of the Criminal Code currently make it illegal for anyone, including a physician, to assist in or cause the death of another person.
- The Supreme Court ordered that the provisions remain in force for 12 months to give Parliament time to respond.
- An external panel was established that consulted with Canadians on options to respond to the Supreme Court's decision in this case. The Panel consulted with medical authorities and interested stakeholders. Consultations were suspended once the federal election was called.
- In December 2015, the province of Quebec introduced assisted dying laws, the only province to do so within the ordered time frame. The first patient utilized this law shortly after its introduction and died with the assistance of a doctor in Quebec City.
- On January 15, 2016, the Supreme Court granted the federal government a four-month extension to pass assisted dying legislation, rather than the six months the government had asked for.
- Following a public consultation that ran from early December 2015 to mid-January 2016, the College of Physicians and Surgeons of Ontario released Policy Statement #1-16: Interim Guidance on Physician-Assisted Death.
- Ontario passed legislation that will support the implementation of medical assistance in dying in the province by providing more protection and greater clarity for patients, their families, health care providers and health care institutions.
- Federal legislation, which came into force in June 2016, sets out the parameters for how medical assistance in dying can be provided.
- Ontario's Medical Assistance in Dying Statute Law Amendment Act aligns with the federal legislation and will address areas that fall under provincial jurisdiction.
- The Medical Assistance in Dying Statute Law Amendment Act will ensure:
    - Benefits, such as insurance payments and workplace safety and insurance benefits, are not denied only because of a medically assisted death
    - Physicians and nurse practitioners, those who assist them, and care provider institutions, are protected from civil liability when lawfully providing medical assistance in dying, except in cases of negligence
    - Identifiable information about individuals and facilities that provide medical assistance in dying are protected from disclosure under access to information requests
    - Effective ongoing reporting and monitoring by the Chief Coroner of Ontario for cases of medical assistance in dying.
- On May 10, 2017, Ontario's Medical Assistance in Dying Statute Law Amendment Act, 2017 came into force upon Royal Assent. It addresses areas relevant to medical assistance in dying that fall under provincial jurisdiction. The legislation provides greater clarity and legal protection for health care providers (including institutions and clinicians) as well as patients navigating medical assistance in dying. The legislation also establishes a new role for the coroner in overseeing medically assisted deaths.
- Health care providers, including physicians, nurses and pharmacists were encouraged to refer to their regulatory colleges for additional professional guidance related to the provision of medical assistance in dying.
- For insured persons, the drugs and services required for medical assistance in dying will be available at no cost to the patient.

- The Ministry of Health and Long-Term Care will also be establishing a care coordination service to assist patients and caregivers in accessing additional information and services for medical assistance in dying and other end-of-life options.
- Ontario has also worked with many health care partners to develop information, tools and training to support patients, caregivers and health care providers on medical assistance in dying-related matters.
- Ontario's health regulatory colleges for physicians, nurses and pharmacists provide additional guidance to help their members provide appropriate medical assistance in dying.
- Ontario has established a Clinician Referral Service to support physicians and nurse practitioners in making effective referrals for patients seeking medical assistance in dying.
- Ontario's approach to medical assistance in dying has also been informed by public consultations, with thousands of Ontarians, health care providers and stakeholders sharing their views through in-person and online consultations.
- Ontario is investing $155 million over three years to improve community-based palliative and end-of-life care.
- Bill 84, Medical Assistance in Dying Statute Law Amendment Act, 2017. This Explanatory Note was written as a reader's aid to Bill 84 and does not form part of the law.
- Various Acts are amended in response to the Federal Criminal Code legislation dealing with medical assistance in dying.
    - The Coroners Act was amended to provide that, in the case of a medically assisted death, the doctor or nurse practitioner who provided the medical assistance in dying shall notify the coroner and provide the coroner with any information necessary to determine whether to investigate the death, and other people with knowledge of the death shall provide the coroner with information on request.
    - The Excellent Care for All Act, 2010 is amended to provide protection against litigation for care providers and for doctors, nurse practitioners and people assisting them for performing medical assistance in dying. (This does not apply where negligence is alleged.)
    - Also, the fact that a person received medical assistance in dying may not be invoked as a reason to deny a right or refuse a benefit or any other sum which would otherwise be provided under a contract or statute.
    - The Minister is required to establish a care coordination service to assist patients and caregivers in accessing additional information and services for medical assistance in dying and other end-of-life options.
    - The Freedom of Information and Protection of Privacy Act and the Municipal Freedom of Information and Protection of Privacy Act are amended to provide that they do not apply to identifying information relating to medical assistance in dying.
    - The Vital Statistics Act is amended to provide that the requirements respecting the coroner's documentation do not apply in cases of medical assistance in dying if the coroner has determined that the death not be investigated.
    - The Workplace Safety and Insurance Act, 1997 is amended to provide that a worker who receives medical assistance in dying is deemed to have died as a result of the injury or disease for which the worker was determined to be eligible to receive medical assistance in dying.

Quality Care Information Protection Act (QCIPA) Review

- The Quality Care Information Protection Act, 2004 (QCIPA) came into force on November 1, 2004.
- QCIPA is designed to encourage health care professionals to share information and have open discussions about improving the quality of health care.
- In July 2014, a review of QCIPA was convened to explore improvements to the Act and related legislation. The review was led by a panel of experts supported by Health Quality Ontario and co-chaired by a Patient Experience Advisor and Physician Leader.

- The Panel submitted the following twelve (12) recommendations to the Minister of Health & Long-Term Care in December 2014:
    1. Strive for a 'just culture';
    2. The intent of QCIPA remains valid and QCIPA should be retained, with recommended amendments, as a tool to further the understanding of what caused some critical incidents;
    3. Develop clear guidance on when and how to use QCIPA;
    4. QCIPA should be amended to ensure appropriate disclosure to patients and families following a critical incident investigation;
    5. Establish an appeal mechanism for the investigation of critical incidents;
    6. Establish a mechanism through which hospitals must share what they have learned from their investigations of critical incidents and their recommendations to prevent future incidents with each other;
    7. Ensure that critical incidents that occur in organizations other than hospitals are thoroughly investigated and the lessons learned are shared with patients, families and other organizations;
    8. Reinforce the role of the Quality Committee of the hospital Board to provide oversight to critical incident related processes and the recommendations of this report;
    9. Patients and families must be informed of the process that will be used to investigate their critical incident, they must be kept informed of the progress of the investigation, and their voice must be represented throughout the review process;
    10. Patients and families must be interviewed as part of the process of investigating the critical incident and be fully informed of the results;
    11. Establish a provincial program to train and support highly skilled staff to investigate critical incidents and communicate with and support patients and families; and
    12. Support hospital staff involved in critical incidents.
- The Quality of Care Information Protection Act, 2016 (QCIPA 2016) is one step closer to becoming law. Bill 119, the Health Information Protection Act, 2016 (HIPA), passed third reading in the Ontario legislature on May 5, 2016.
- Once proclaimed into force, HIPA will repeal the Quality of Care Information Protection Act, 2004 (QCIPA) and replace it with QCIPA 2016. HIPA will also amend the Personal Health Information Protection Act, 2004. In light of the broad overhaul of QCIPA, health facilities will need to undergo a comprehensive review of their risk and quality policies, processes and systems.
- Since QCIPA came into force, one of the main criticisms of the legislation has been its stringent restriction on the disclosure of quality of care information, even in circumstances where a health facility may wish to disclose.
- QCIPA 2016 incorporates a new preamble and purpose statement, which balance the need for health facilities to engage in confidential discussions about errors, systemic issues and opportunities for quality improvement in health care delivery, with the right of patients to access information about their health care.
- *Critical Incident* – QCIPA 2016 includes a new definition of "critical incident." A critical incident is defined as, "any unintended event that occurs when a patient receives health care from a health facility that, (a) results in death, or serious disability, injury or harm to the patient, and (b) does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing the health care." This is the same definition that is applicable to public hospitals, which are already subject to disclosure of critical incident requirements.

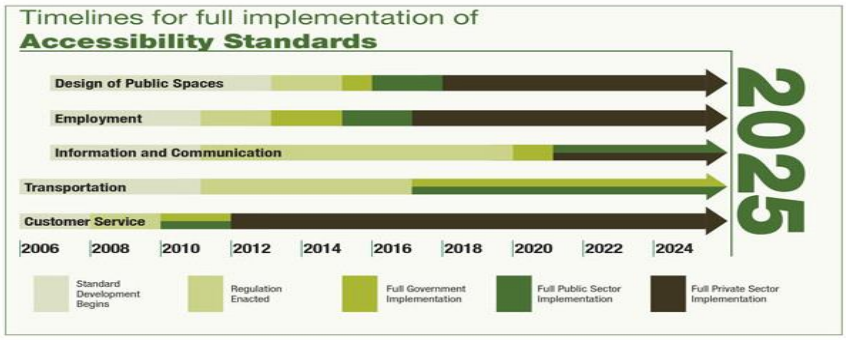
- *Health Facility* – QCIPA 2016 applies to a "health facility," which is defined as a public hospital, private hospital, psychiatric facility, independent health facility or a "prescribed entity that provides health care." Current regulations under QCIPA provide that long-term care homes, laboratories or specimen collection centres are "prescribed entities" for the purposes of QCIPA. Regulations will need to be developed pursuant to QCIPA 2016, including in regards to "prescribed entities".
- *Quality of Care Committee* (QCC) – This is defined as a body of one or more individuals that performs quality of care functions and that is established, appointed or approved by a health facility or a combination of health facilities. This definition is largely the same as under QCIPA. However, under QCIPA 2016, a QCC can be established jointly by more than one health facility.
- *Quality of Care Functions* – QCIPA 2016 defines quality of care functions to include "activities carried on for the purpose of studying, assessing or evaluating the provision of health care with a view to improving or maintaining the quality of the health care." In addition, QCIPA 2016 explicitly includes conducting reviews of critical incidents.
- *Quality of Care Information* – "Quality of care information" has been redefined under QCIPA 2016 and expressly includes information that "relates to the discussions and deliberations of a [QCC] in carrying out its quality of care functions," as well as, "information contained in records that a [QCC] creates or maintains related to its quality of care functions."
- The definition explicitly excludes information relating to a patient in respect of a critical incident that describes: the facts of what occurred; what the QCC has identified as the cause or causes of the incident; the consequences of the critical incident to the patient as they become known; the actions taken and recommendations made to address the consequences; and, the systemic steps, if any, that a health facility is taking or has taken to avoid or reduce the risk of further similar incidents.
- *Critical Incident Reviews* – In conjunction with these changes, amendments to Regulation 965 under the *Public Hospitals Act* have been proposed that would impose additional requirements on hospitals with respect to critical incident reviews. These amendments require the establishment of a system for ensuring that a committee appointed by the hospital reviews every critical incident as soon as is practicable after the critical incident occurs. This committee must include a patient relations coordinator. In addition, there is a requirement to offer to interview the patient during the review process. Health facilities cannot withhold critical incident information from affected patients.
- Under QCIPA 2016, investigations of critical incidents can involve multiple health facilities. QCIPA 2016 explicitly permits the sharing of quality of care information between QCCs. However, this information sharing process cannot disclose more personal health information than is reasonably necessary to conduct quality of care functions.
- QCIPA 2016 allows the Minister of Health and Long-Term Care to make regulations restricting or prohibiting the use of QCCs for the purposes of reviewing critical incidents
- In light of the changes to QCIPA, health facilities are encouraged to conduct a comprehensive review of their risk and quality improvement policies, particularly with respect to critical incident reviews and disclosure. Health facilities will need a system in place to consider the threshold issue of whether a particular incident is a "critical incident" within the QCIPA 2016 definition
- In addition, despite the ability to share more information with patients, the restrictions against disclosure of quality of care information still apply in the context of legal proceedings and limit the ability of health facilities to use such information in the context of related professional practice, credentialing and performance management processes. Health facilities must ensure that processes are in place so that identified discrepancies or professional practice issues can be investigated and reviewed outside of the QCIPA 2016 framework

Accessibility for Ontarians with Disabilities Act, 2005

- The Accessibility for Ontarians with Disabilities Act (AODA) 2005 provides for mandatory progressive change to help improve the lives of people with disabilities. Hospitals and other organizations will have to meet certain accessibility standards in five areas:
    - Customer service;
    - Employment;
    - Information and communications;
    - Transportation; and
    - Design of public spaces
- To comply with requirements, SAH has implemented all requirements under the customer service standard including developing an accessibility policy and making it available in an accessible format and providing training for all staff. Under the employment standard, hiring is accessible, staff members are informed of policies in place for supporting employees with disabilities, and accommodation plans can be developed for employees with disabilities. Under the information and communication standard, the way SAH receives and responds to feedback can be made accessible when asked. New web content conforms to Web Content Accessibility Guidelines 2.0.
- By 2021, SAH must implement all requirements of the information and communications standard by making information about all services and facilities accessible when asked and ensure all public websites and web content posted after January 1, 2021 conforms to Web Content Accessibility Guidelines 2.0.
- On June 3, 2015, Ontario celebrated the 10th anniversary of the Accessibility for Ontarians with Disabilities Act and launched The Path to 2025: Ontario's Accessibility Action Plan. The Action Plan focuses on three priority areas:
    1. Engaging businesses;
    2. Strengthening our foundation; and
    3. Promoting a culture of accessibility.
- Some new initiatives announced in the Action Plan include:
    - Investing $9 million over two years to support and promote the employment of people with disabilities;
    - Exploring voluntary third party accessibility certification; and
    - Hosting an Accessibility Innovation Showcase around the Pan/Parapan American Games.

The 2017 AODA requirements:

- Make new or redeveloped public spaces accessible
    - outdoor public use eating areas
    - public outdoor paths of travel
    - on and off street parking areas
    - accessible service counters
    - fixed waiting lines
    - waiting areas with fixed seating



Fair Workplaces and Better Jobs Act, 2017 (Bill 148)

- On June 1, 2017, Ontario introduced legislation to create more opportunity and security for workers through its plan for Fair Workplaces and Better Jobs, including hiking the minimum wage, ensuring part-time workers are paid the same hourly wage as full-time workers, introducing paid sick days for every worker and stepping up enforcement of employment laws.
- The Fair Workplaces, Better Jobs Act, 2017 would:
    - Raise Ontario's general minimum wage to $14 per hour on January 1, 2018, and then to $15 on January 1, 2019, followed by annual increases at the rate of inflation
    - Mandate equal pay for part-time, temporary, casual and seasonal employees doing the same job as full-time employees; and equal pay for temporary help agency employees doing the same job as permanent employees at the agencies' client companies (April 1, 2018).
    - Expand personal emergency leave to include an across-the-board minimum of at least two paid days per year for all workers
    - Align Ontario's vacation time with the national average ensuring at least three weeks' vacation after five years with the same employer
    - Make employee scheduling fairer, including requiring employees to be paid for three hours of work if their shift is cancelled within 48 hours of its scheduled start time (Jan. 1, 2019)
    - Public Holiday Pay - The proposed changes would simplify the formula for calculating public holiday pay so that employees are entitled to their average regular daily wage. Other elements of the public holiday provisions would also be simplified. (January 1, 2018)
    - Physician Notes for Absences - The proposed changes would prohibit employers from requesting a sick note from an employee taking Personal Emergency Leave. (January 1, 2018)
    - Family Medical Leave - The proposed legislation would increase Family Medical Leave from up to 8 weeks in a 26-week period to up to 27 weeks in a 52-week period. (January 1, 2018)
    - Additional areas include:
        - Leave for the Death of a Child and for Crime-Related Disappearance
        - Paid Emergency Leave
        - Changes to Overtime Pay
        - Termination of Assignment

To enforce these changes, the province will hire up to 175 more employment standards officers and launch a program to educate both employees and small and medium-sized businesses about their rights and obligations under the Employment Standards Act.

Quick Facts

- The Changing Workplaces Review, conducted by Special Advisors C. Michael Mitchell and John C. Murray over the past two years, estimated that more than 30 per cent of Ontario workers were in precarious work in 2014. This type of employment makes it hard to earn a decent income and interferes with opportunities to enjoy decent working conditions and/or puts workers at risk.
- In 2016, the median hourly wage was $13.00 for part-time workers and $24.73 for full-time workers. Over the past 30 years, part-time work has grown to represent nearly 20 per cent of total employment.

- Currently, half of the workers in Ontario earning less than $15 per hour are between the ages of 25 and 64, and the majority are women.
- More than a quarter of Ontario workers would receive a pay hike through the proposed increase to the minimum wage.
- Studies show that a higher minimum wage results in less employee turnover, which increases business productivity.
- Ontario is proposing a broad consultation process to gain feedback from a wide variety of stakeholders on the draft legislation it has introduced. To facilitate this consultation, it is proposing to send the legislation to committee after First Reading.

Executive Compensation:

- The government has enhanced the Regulation to align compensation programs with the expectations communicated in a memo from February 3, 2017.

- Building on the existing requirements in the Broader Public Sector Executive Compensation Act, 2014, designated employers must now adhere to the following additional criteria:

    - Employers are now required to set out the maximum rate of increase to their overall executive compensation envelope to ensure transparency around planned and actual increases to compensation while providing employers the flexibility to determine individual salary levels over time.
    - Overseeing Minister approval will be required on two components of proposed executive compensation programs:
        - the comparator organizations used to benchmark compensation levels for executive positions; and
        - the proposed maximum rate of increase to the executive compensation envelope.
- Employers will now have until September 29, 2017 to submit their proposed executive compensation programs for government review.

- Designated employers are also authorized to make annual adjustments to salary and performance-related pay caps. Such adjustments may not exceed the lesser of the provincial public sector wage trend and the average rate of increase of an employer's non-executive managers.

- Changes to the Broader Public Sector Executive Compensation Act, 2014 are understood as follows:
    - A new 6 step approval and public consultation process that directly involves the Ministry of Health is forthcoming, potentially:
        - before the hospital can post their framework they must send their final draft framework to government for feedback (by Sept. 29th),
        - once approved by the Minister, the hospital will post their framework for public consultation,
        - the hospital is then to consider public feedback and amend (or not),
        - the hospital is then to send a summary of the public feedback to government as well as any amendment to framework,
        - final approval from government (Minister approval) and
        - final approval by board
    - A funding envelope and maximum rate of increase will be introduced and set by government.
    - Government has committed to education for hospitals.
    - Timeline for submission to government of hospital draft executive compensation frameworks will be extended to Sept 29th.

- The Ontario government must now approve the comparators broader public sector organizations use when determining appropriate salaries, the caps on the salaries themselves and the overall rate of increase for all executives.
- All broader public sector agencies have until September to post their proposals for new executive compensation packages under a framework that caps salaries at the 50th percentile of "appropriate comparators."
- Broader public sector organizations now must get their comparators approved before posting proposed executive compensation changes.
- Some organizations will also be allowed to boost salaries each year, though the annual raises can't exceed the Ontario public sector wage increase trend — this year at 1.3 per cent — or the average rate of increase for an organization's non-executive managers.
- The government would deny "unreasonable adjustments to compensation," according to the memo.

On June 9, 2017, Liz Sandals, President of the Treasury Board, Legislative Assembly of Ontario, sent a memo entitled "Update on the approach to broader public sector executive compensation" to clarify the government's expectations for developing executive compensation programs. The memo:

- set out guidance for selecting comparators and program contents, managing adjustments to compensation and providing the public with an effective opportunity to comment on the contents of proposed programs.
- explained that government would be taking a more active role in ensuring that programs are understandable to the public.
- Noted that in the intervening months, the government has sought the input of key stakeholders to find a balance between the careful management of public dollars and the need for broader public sector entities to recruit and retain talented executives.

The Executive Compensation Framework Regulation (the Regulation), established under the Broader Public Sector Executive Compensation Act, 2014 (BPSECA), sets out requirements that designated broader public sector (BPS) employers must meet when establishing executive compensation programs.

The regulation came into force on September 6, 2016, and was introduced to ensure the responsible and transparent administration of executive compensation across the broader public sector.

-Today, I am writing you to inform you of key updates to our approach to BPS executive compensation. The government acknowledges that a significant amount of work has already been undertaken by employers to date, and has structured the changes to the Regulation to ensure that work remains valuable.

Guidance Materials and Next Steps

-To provide guidance and clarity to designated employers and overseeing ministries, the government has developed a user guide that includes templates, which will facilitate executive compensation program development. It is expected that employers work closely with their overseeing ministry to ensure that executive compensation programs meet regulatory requirements.

To help ensure that proposed executive compensation programs are reviewed in an expeditious manner, designated employers are advised to contact their overseeing ministry when developing their executive compensation programs for guidance and support through the process.

Threats

There were immediate concerns that the proposed changes to the regulation would severely erode board governance and are too prescriptive. There are significant concerns with introducing new concepts at this very late stage; the process is highly politicized, costly and wasteful.

Workplace Violence Prevention in Health Care Project
Summary

The health care sector, which represents 11.7% of Ontario's labour market, is the largest sector affected by violence in the workplace. 56% of lost-time injuries due to workplace violence in the hospital sector occur among Registered Nurses.

On May 15, 2017, the Ontario Ministry of Health and Long-Term Care and Ministry of Labour released a progress report on the first year of its joint Workplace Violence Prevention in Health Care project.

The focus of the first year has been on reducing the risk of violence for nurses working in hospitals.

The progress report includes 23 recommendations that were developed by the Workplace Violence Prevention Leadership Table and its Working Groups.

The recommendations include several process enhancements that are aimed at hospitals, such as:

- Including workplace violence indicators in hospitals' quality improvement plans (QIPs);
- Providing increased supports for patients with known aggressive behaviours;
- Seeking patient, family and staff input about triggers and interventions; and
- Creating a reporting system for workplace violence incidents.

One critical issue that remains unresolved is the need for additional resources.

There must be zero tolerance for workplace violence.

The focus is to enhance four critical components of a safe workplace culture:

- Leadership and accountability,
- Hazard prevention and
- Control, indicators, evaluation and reporting,
- Communication and knowledge translation.

The Act focuses on reducing the risk of violence for nurses working in hospitals who, because of their close contact with patients and families, are the most common victims of workplace violence in the health care sector.

The Act highlights the need to engage everyone — patients and families, front-line staff, Joint Health and Safety Committees (JHSC), health and safety representatives, unions, people responsible for hospital security, managers, senior leadership, community-based services, police, professional associations, health and safety associations and the general

It also emphasizes the critical importance of understanding and addressing all factors that contribute to the violent incidents that occur in hospitals, and using all possible levers and strategies to reduce risk.

Recommendations:

- Create transition teams – sustainable groups of experts to assist/provide advice with the implementation of workplace violence prevention tools and leading to improve a hospital's journey to excellence.
- Create a workplace safety environmental standard for healthcare workplaces.
- Develop resources and supports to help hospitals create a psychologically safe and healthy workplace based on the CSA standard.
- Amend the *Occupational Health and Safety Act* to allow a designated worker member of the JHSC to be included in workplace violence investigations under certain circumstances.
- Amend the *Occupational Health and Safety Act* to create a requirement about the information to be provided to a worker who experienced a violent incident.

- Include more details on legislative compliance and requirements in the workplace violence section of the Ministry of Labour's (MOL) health care sector plan.
- Strengthen workplace violence language in Accreditation Canada's Required Organizational Practice.
- Strengthen workplace violence language in Accreditation Canada's Standard.
- Amend the Ministry of Labour Policy and Procedure manual to ensure all risk assessments conducted by hospitals are adequate.
- Promote the use of all existing and future Public Service Health and Safety Association (PSHSA) Violence, Aggression and Responsive Behaviour tools in all Ontario hospitals.
- Ask the PSHSA, in collaboration with stakeholders, to develop additional tools to support:
    - incident reporting and investigation (root cause analysis)
    - code white
    - patient transit (inside the facility) and transfer (outside of the facility)
    - work refusal procedures
- Develop specific supplementary tools through the Leadership Table in the second phase and out-years of the project.
- Provide more supports for patients with known aggressive or violent behaviour within health care facilities and in the community.
- Create and implement a standard provincial form/process to engage a patient and/or family/caregiver in developing a patient's care plan that includes safety for workers.
- Work with the College of Nurses of Ontario to provide more clarity related to nurses' right to refuse to provide care to patients in hazardous situations, where the hazard is workplace violence.
- Require post-secondary institutions to provide students with enhanced training in workplace violence and prevention before entering the workforce.
- Develop and implement a consistent minimum provincial training standard for those performing the role or function of providing security in hospitals.
- Address issues related to workplace violence incident reporting systems, including:
- Conduct assessments (by hospitals) to ensure that reporting systems capture workplace violence incidents that result in psychological as well as physical injuries
- Communicate clear consistent messages (from hospital leadership and the joint ministries) about: how staff should report violence incidents, the action that will be taken based on workplace violence reports, and what staff can do if they feel action is not being taken
- Evaluate reporting system effectiveness across Ontario hospitals to capture all workplace violence incidents and ensure quality
- Collect information on resources hospitals require to develop reliable, valid and comprehensive reporting structures and to capture information in key indicators; identify actions to address any information gaps
- Develop clear definitions of flagging, root cause analysis, and appropriate use of force, and communicate them to hospitals and hospital staff
- Ensure that the calling of code whites is consistent across hospitals (i.e. in response to similar environmental factors), and that call response procedures are similar across hospitals; this will ensure these indicators are measured consistently across organizations
- Evaluate reporting systems in collaboration with other system stakeholders to ensure consistent data collection for both workplace violence incidents and prevention activities over time
- Attempt to better understand, address and communicate deficiencies in the use of workers' compensation claim data as the only source of work-related injury surveillance
- Include workplace violence prevention in Quality Improvement Plans.
- Create consistent communication protocols between hospitals and external care environments to limit the risk of violence to healthcare workers and patients.
- Expand an existing communication protocol to prepare a health care facility to receive an incoming patient for a psychiatric assessment.
- Implement a joint ministry public campaign regarding the Workplace Violence Prevention in Health Care project.
- Post information about all MOL fines against employers in health care under $50,000.

The Protecting Patients Act, 2017

The Protecting Patients Act received Royal Assent on May 30, which includes legislative amendments to:

- Expand the list of acts of sexual abuse that will result in the mandatory revocation of a regulated health professional's certificate of registration
- Remove the ability of a health regulatory college to impose restrictions that would allow a regulated health professional to continue practicing on patients of a specific gender
- Ensure more timely access to therapy and counselling for patients who make a complaint of sexual abuse by a regulated health professional to a health regulatory college
- Require that more information regarding the current and past conduct of regulated health professionals is available to the public in an easy-to-access and transparent way
- Incorporate feedback from stakeholders, including establishing a higher threshold for when third-party records may be ordered to be produced in discipline hearings involving sexual abuse.

Additional amendments that were passed to help people in Ontario stay healthy and safe include:

- Immunization of School Pupils Act is amended:
    - To require parents to complete an immunization education session before filing a statement of conscience or religious belief.
    - To expand the categories of persons who may provide statements regarding the administration of immunizing agents.
    - To require those who administer immunizing agents to provide information to the local medical officer of health.
- Improving the way immunizations are reported, which will help prevent children from being suspended from school for required school immunizations
- Helping parents make informed decisions about immunizing their children if they are considering a non-medical exemption
- Improving and modernizing Elderly Persons Centres to help seniors stay healthy, active and engaged
- Making it easier and more convenient for people to receive coverage under the Ontario Drug Benefit (ODB) Program for prescriptions that are written by nurse practitioners, and in the future, other authorized prescribers for products such as diabetes testing strips and nutritional products
- Continuing to ensure that community laboratory services are safe and effective by updating inspection provisions and streamlining licensing requirements.

Quick Facts

- With the passage of the Protecting Patients Act, the government is able to make legislative amendments to several statutes that will ensure that patients in Ontario are healthy and safe.
- Ontario's health care budget will total $53.8 billion in 2017–18 — a 3.8 per cent increase from the previous year.
- As part of the 2017 Budget, Ontario is providing $8 million over the next three years to allow for an additional 40 new Elderly Persons Centres by 2018–19, to meet the growing needs of seniors and help support some of Ontario's most vulnerable populations.

Patients First: Ontario's Action Plan for Health Care

- Launched in February 2015, Patients First: Ontario's Action Plan for Health Care is the next phase of the Ontario Government's commitment to transform the health care system into one that puts the needs of patients at its centre. The Patients First Plan builds on the first Action Plan for Health Care launched in 2012.

- The objective of the Patients First Plan is to put people and patients first by improving their health care experience and their health outcomes. The Plan focuses on 4 key objectives:
    1. Access;
    2. Connect;
    3. Inform; and
    4. Protect.
- Building on the initial action plan, on December 17, 2015, the MOHLTC released a discussion paper entitled Patients First: A Proposal to Strengthen Patient-Centred Health Car in Ontario. It delves into the initial 4 key objectives by outlining 4 Proposals. The Ministry has asked for feedback from Ontarians by February 29, 2016.
- The Patients First Act (Bill 41) passed in December 2016, focusing on:
    - Support and improve access to home and primary care – all Community Care Access Centres to be eliminated and duties and responsibilities transferred to local LHINs
    - Put patients and their families at the centre of health care
    - Improve local connections for more integrated planning, better coordination of care that reflects the needs of the community
    - Streamline and make administration more efficient
    - Increase focus on cultural sensitivity, with emphasis of First Nations, urban Indigenous, Metis and French-speaking Ontarians

Results of Patient's First Act initiatives (2017)

ACCESS Results:

- Expanded the number of community Health Links from 69 to 82 across the province, providing better coordinated care for patients with multiple, complex conditions.
- Increased access to fertility services at 52 clinics across the province. Ontario will now fund one in-vitro fertilization cycle per eligible patient.
- Additional $83 million invested in mental health and addictions services, supporting more than 200 community initiatives.
- In 2015-16, close to $1.4 billion was invested to expand, renew and modernize hospitals with approximately 40 major hospital projects under construction or in various stages of planning.
- Making hospital parking more affordable by requiring hospitals that are charging more than $10 a day to provide 5-, 10- and 30-day parking passes at 50% the daily rate or less starting October 1, 2016. All hospitals will also cap their daily rates for three years.

CONNECT Results:

- Expanding home and community care in Ontario by implementing Patients First: A Roadmap to Strengthen Home and Community Care — a 10-step plan to improve and expand home and community care over the next two years.
- Consulting with stakeholders and the public on primary care and home care changes to improve the connections and communications between health care providers, hospitals, and home and community care.
- Six teams in Ontario are now implementing bundled care to help patients transition more smoothly from hospital to home, enabling care providers to work as a team to ensure a better patient experience.
- Allowing more in-home care for patients, though 30 community paramedicine programs.

INFORM Results:

- Launched the Healthy Kids Community Challenge which takes a community-wide approach to healthy eating, physical activity and healthy behaviours for children.
- Passed The Healthy Menu Choices Act, 2015 requiring food service premises with 20 or more locations in Ontario to post calorie information for standard food and beverage items on their menus as of January 1, 2017. This will help Ontarians make more informed decisions about healthier food choices.

- Released Immunization 2020, Ontario's five year strategy to strengthen the immunization system to better protect all Ontarians from vaccine preventable diseases, including a public education campaign and strengthening the rules for those who choose not to vaccinate their school-aged children.
- Helping to reduce smoking rates by making it harder for youth to obtain tobacco products, banning the sale of flavoured tobacco and banning the sale of e-cigarettes to anyone under the age of 19.

PROTECT Results:

- Making prescription refills more convenient for people with chronic conditions and making changes to ensure Ontarians get good value when it comes to drug costs now and in the future.
- Selected Ontario's first-ever Patient Ombudsman following a recruitment process that included input from nearly 1,000 individuals from across Ontario.
- Introduced the Health Information Protection Act to ensure the protection of patients' personal health information and increase transparency in Ontario's health care system.
- Recruited a Chief Health Innovation Strategist to make sure Ontario is taking the most innovative approach to delivering health care and championing the province as a leading centre for new health technology.

Source: Ministry of Health & Long-Term Care (2015). *Patients First: Ontario's Action Plan for*

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External Environment – Economic and Funding Reform

Summary

The Ministry of Health and Long Term Care continues to implement health system funding reform. The funding reform continues to transition from a provider-centred funding approach towards a patient-based funding (PBF) model, where funding is based on services provided. A dedicated QBP Steering Committee exists and SAH has invested in education to become more predictive of future funding.

HSFR has positively impacted SAH in 2017/2018 when SAH's funding was increased by approximately $5.5 million. However, the increase is expected be temporary with a substantial decline in 2018/2019 as the increase was driven by a one-time increase in patient volumes when a large number of long stay patients were discharged to Interim Long Term Care beds.

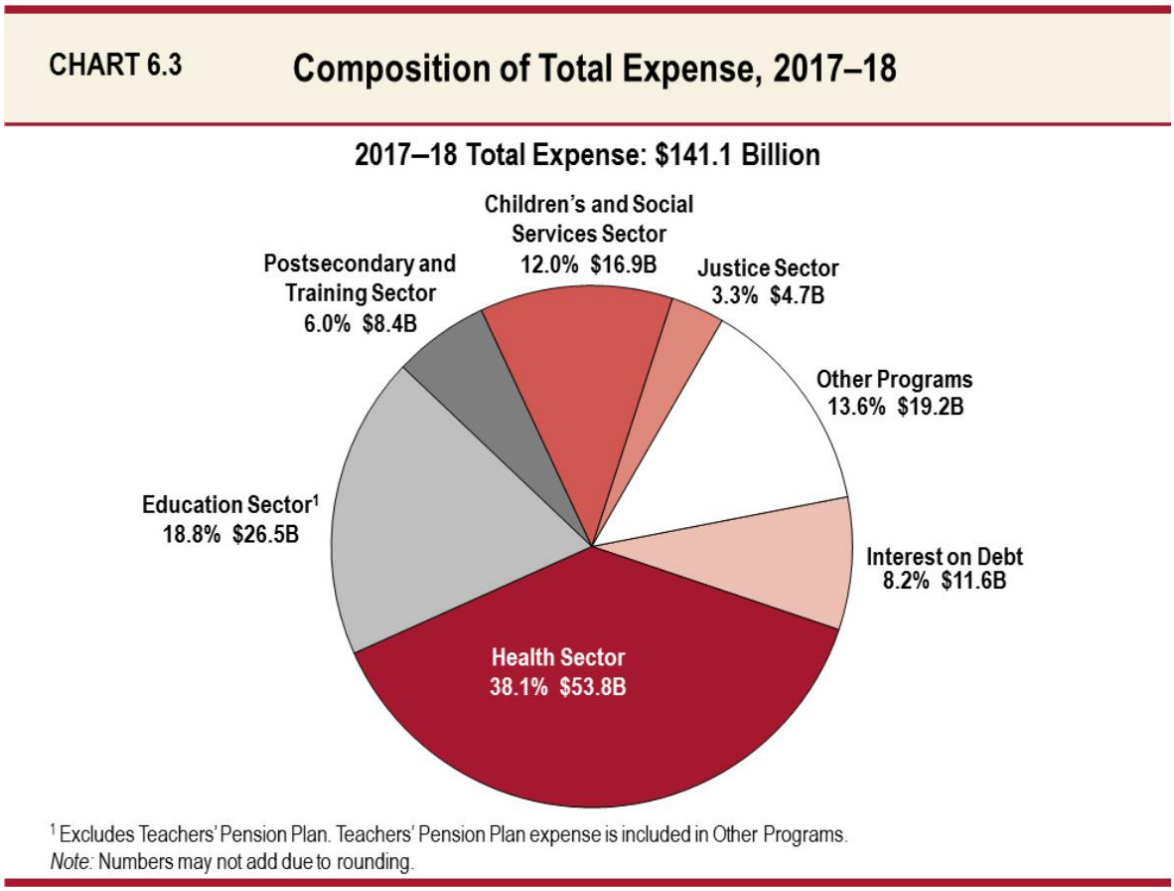
Highlights

Health System Funding Reform (HSFR):

- In January 2012, Ontario's Action Plan for Health Care was introduced. Under that Action Plan, the health care system began moving away from a global funding system to a model that primarily follows the care that patients need and will be provided to them.
- Under the new funding model, Ontario's hospitals are compensated based on how many patients they look after, the services they deliver, the evidence-based quality of those services, and the specific needs of the broader population they serve.
- The main benefits of Health System Funding Reform (HSFR) include:
    - Patient-centred care, which will focus on individuals and ensure that funding is tied more directly to the quality care that is needed and will be provided; and
    - Smarter use of limited resources, which will drive a sustainable health care system based on quality.
- In the end state, HSFR will comprise 70% of the funding envelope provided to hospitals with the remaining 30% based on global funding.
- There are two key components to HSFR :
    - Organizational-level funding (will comprise approximately 40 per cent of HSFR allocation): Funding is allocated to hospitals and Community Care Access Centres using the Health Based Allocation Model (HBAM).
    - Quality-Based Procedures (will comprise approximately 30 per cent of HSFR allocation): Funding is allocated to specific procedures based on a "price X volume" approach. This involves providing evidence-based allocations to targeted clinical groups. The price is structured to provide an incentive and adequately reimburse providers for delivering high-quality care.
- HSFR has created significant variability to the funding SAH has received year to year.
- Ministry methodology changes have impacted the ability to accurately predict future funding.

2017 Ontario Budget

- On April 27, 2017, Finance Minister Charles Sousa tabled a $141 billion spending plan for Ontario, of which 38.1% or $53.8 billion is for the health sector.



SOURCE: Ontario Budget 2017

Key highlights include:

- **Eliminated Budget Deficit**: Eliminated the provincial deficit; Continuing its approach to organizing primary health care providers and teams around the needs to the population across the province;
- **Sector Expense: Health sector's** expense is projected to grow on average by 3.3 per cent per year between 2015–16 and 2019–20 as a result of targeted funding for hospital services, reduced wait times, new children and youth pharmacare, investments to increase access to primary care, home care and community care, and increased supports for people requiring mental health and addictions services;
- **Free Prescription Medications:** Providing free prescription medications to all children and youth aged 24 and under starting in January 2018 — the first province in Canada to do so. This will include medications to treat most acute conditions, common chronic conditions, childhood cancers and other diseases;
- **Hospital Construction:** Support for the construction of major new hospital projects across the province to support the delivery of services and give people faster access to care. $9-billion capital investment over 10 years;
- **Shorter Wait Times**: Continue meeting increasing demands as communities across Ontario grow. $1.3 billion in support for hospitals to improve access to timely care with shorter wait times and greater access to services for patients and their families;

- **Primary Care**: Enhancing primary care to make it easier to get services offered by physicians, nurses, social workers and other health care professionals;
- **Indigenous Health Care**: Investing in the health and wellness of Indigenous communities is a top priority. Expanding programs such as midwifery services, mental health and addiction initiatives — and continuing to support long-term care homes for Indigenous health care;
- **Home and Community Care:** Providing more home and community care through home nursing, personal support, physiotherapy and respite care services with an additional investment of $250 million this year;
- **Specialized Care**: Increasing access to more specialized health care, including hip or knee replacements, MRIs and optometrist services, to deliver high-quality care and reduce wait times;
- **Mental Health Services**: Funding mental health and addiction initiatives, such as structured psychotherapy, supportive housing and youth services;
- **Long-term Care:** Increasing funding to long-term care homes and services to improve residential care with healthier food and more specialized staff, by increasing long-term care funding by $58 million and increasing the food allowance for long-term care homes by $15 million;
- **Dementia Strategy**: Improving services for people living with dementia and their caregivers, including more than $100 million over three years. The strategy will help people access better coordinated care and enhanced services once a diagnosis is made;
- **Maternal and Child Health Care**: Supporting health care for mothers, babies and children with expansion of midwifery, prenatal screening and a new infant hearing screening programs;
- **Pain Management Clinics:** Developing chronic pain management programs at 17 hospitals and community clinics;
- **Fetal Alcohol Spectrum Disorder:** Enhancing services to improve the quality of life for children, youth and families affected by Fetal Alcohol Spectrum Disorder;
- **Health Innovation**: We know the valuable role that innovation and technology play in our health care system. To address this changing environment, we've announced the upcoming action plan for Digital Health in Ontario; and
- **Budget Talks - Accessing Digitized Health Data**: This pilot was one of the top three ideas selected by the public for funding through the Budget Talks platform. Developing a proof-of-concept digital registration and public authentication service that will allow parents and/or guardians to securely and easily access their child's "Yellow Card" immunization records electronically, using their banking credentials. This digital process may be expanded to test a Patient's First Access Channel where patients can find their health data (e.g., lab records, current medications, hospital visits) regardless of where the digital record actually resides. The idea will receive a one-time investment of $1 million in 2017–18.

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External Environment – Technology, Innovation and Research

Leverage technology and innovation to improve patient care by having the right information to the right people at the right time 24 hours per day.

Highlights

- There continues to be pockets of information and technology across the community, region and province without a consistent approach to consolidate and standardize the information so it can be easily accessed and shared in a safe and secure manner. This needs to change moving forward in order to make efficient use of technology and its related costs.
- Health information technologies can make patients safer and improve health care. It can also control health spending by reducing costly complications and preventing unnecessary hospitalizations. Technology, such as electronic recording, would improve care by preventing duplication of tests/treatments and reducing errors in care.
- Use of remote patient management technologies will increase with the expansion of new delivery models, and may have a significant impact on inpatient days. Deployment of remote management technologies will increase as their contributions to productivity and quality are recognized.
- Telemedicine and Telehealth services will be an integral part of health care delivery and will be used to address geographic access barriers in rural and underserved communities, as well as in urban areas.
- Information governance will grow in importance over the next decade. As government increasingly resorts to health care analytics, individual institutions will be forced to continually review their information to ensure that it is accurate and the government is fully informed of contextual issues.
- Information technology supporting both business processes and care processes will consume a growing percentage of operating budgets, driven by regulatory mandates and business imperatives.
- New technologies will positively impact health status and longevity, but, on balance, will increase health care spending because of the costs of implementing and delivering them and because of the additional health costs incurred as people live longer.
- Forty percent of physicians surveyed said they could eliminate 11% to 30% of office visits through the use of mobile health technologies like remote monitoring, email or text messaging with patients.

eHealth Governance 2.0

- The Ministry of Health & Long-Term Care (MoHLTC) is taking steps to ensure that investments in eHealth advance the objectives of the Patients First: Action Plan for Health Care beginning with eHealth Governance 2.0. The MoHLTC has established the eHealth Investment and Sustainment Board to engage the health system in renewing the provincial strategy for eHealth. The MoHLTC will be consulting with patients and their caregivers, providers, and other health system partners on how best to renew Ontario's eHealth strategy.
- Chaired by Deputy Minister Bob Bell, the mandate of this new Board is to provide advice to the MoHLTC on eHealth Strategy 2.0 and monitor its implementation.
- This new Board can establish advisory panels to provide expert counsel on critical, time-sensitive issues that will inform eHealth Strategy 2.0. The Board has formed the Hospital Information System (HIS) Renewal Advisory Panel which will be co-Chaired by Donna Cripps, CEO of Hamilton Niagara Haldimand Brant Local Health Integration Network and Murray Glendining, President and CEO of London Health Sciences Centre.

- This Advisory Panel will provide guidance on a range of issues, including best practices for consolidated procurements, methodologies to accurately estimate the cost of HIS renewal, expectations for the meaningful use of existing hospital information systems, alternative financing options, and how future HIS renewal could benefit from eHealth Ontario's integration services.
- The MoHLTC has made it clear that there will not be any separate or additional Ministry financing for HIS renewal. It has asked hospitals to pause HIS procurements including partnering with other hospitals to leverage existing contracts, to allow the Advisory Panel to be established and provide advice. It could take up to 6 months before recommendations come forward from the MoHLTC.

Patients First: Action Plan for Health Care is the next phase of Ontario's plan for changing and improving Ontario's health system, building on the progress that's been made since 2012 under the original Action Plan for Health Care.

In support of the *Patients First* plan and acknowledging the significant changes in the health sector and the opportunities created by advances in technology since the original 2008/09 eHealth strategy, the ministry has initiated the eHealth 2.0 strategy as an initiative to enhance how eHealth effectively supports and enables the Ministry's business priorities and the next phase of health system transformation.

As a leading element of the eHealth 2.0 strategy initiative, HIS renewal represents an opportunity to advance Ontario's *Patients First* objectives by helping transform Ontario's fragmented HISs into a platform for a high-performing, better connected, more integrated, and patient-centred health care system.

To reduce duplication of effort and resources across hospitals, and internally a need for standardization with respect to data and clinical models, emerged.

The next generation of HIS investments (forecasted under current conditions to be in the $2B range now underway is seeing movement towards partnership and collaboration to increase value spurred by an environment of fiscal constraint:

The focus on partnership will initially build on existing relationships to move onto common, shared HIS instances and services with a goal of realizing efficiencies and economies of scale, as well as accelerated hospital adoption of electronic health information and clinical functionality for hospital-specific enhanced patient outcomes.

Increasingly driven by evidence that appropriate clustering of hospitals (patient referral based, geographic based on shared patient population, or thematic- based on clinical specialty) for common HIS services can lead to additional benefits associated with improved quality of care and health system integration.

There is a strong demand from the sector and LHINS for direction and an enabling framework for HIS Services delivery, particularly with respect to clustering and related models for increased value of HIS investments.

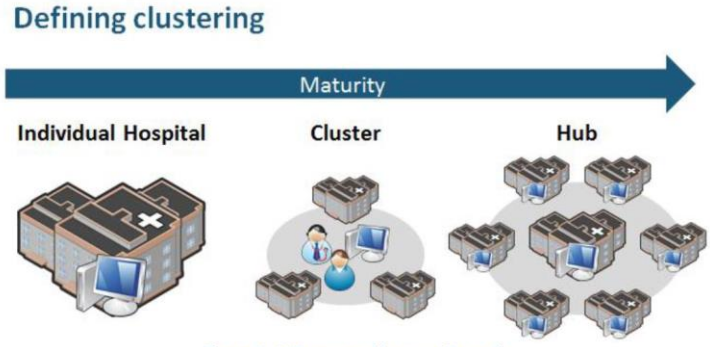

Figure 1 - HIS partnership maturity path

LOCAL HIS UPDATE

SAH's current Hospital information System (Meditech) provides hospital with a hybrid patient record (part paper/part electronic) which is causing frustration for physicians and clinical staff that use the system and as a result, having a negative impact on patient care.

The SAH strategic goal is to move to a full electronic patient record that can be shared seamlessly within our community. That requires either an upgrade or replacement of the SAH current system.

The North East Local Health Integration Network (NE LHIN) has expanded the initiative into the implementation of a regional solution rather than a single site solution – this will now include all of the North Eastern Ontario Network (NEON) hospitals: North Bay Regional Hospital, West Parry Sound, and SAH.

HIS Benefits for Patients

QUALITY CARE
A single Northeastern hospital information system for data collection and management is key to achieving efficiencies and improvements in patient care and safety by linking medical and regulated health care professionals. This single system will also facilitate a platform for further participation across providers, as well as population health planning.

EQUITABLE CARE FOR ALL
Investment in a common hospital information system improves care for ALL patients – as it is the one tool that touches all patients as they receive hospital care across the region.

ONE RECORD PER PERSON
Patients transferred from one hospital to another won't have to undergo duplicate tests or tell their "story" over and over. Their record will be complete and understood by all through technology that's aligned with that being used by the rest of the province.

CLINICAL TRANSFORMATION
A key opportunity for care standardization of best practices to enhance patient safety and outcomes, and to reduce harm.

The "ONE" Initiative

The **"ONE"** initiative (a.k.a. **One Person. One Record. One System.**) is about improving quality of care and improving the ease of delivering that care.

To support these objectives, we are using a North East Local Health Integration Network (NE LHIN) Health Information System (HIS) Roadmap with three strategies:

1. The installation of Meditech 6.1x North East master site that will serve as the regional EMR for all 24 acute hospitals.

2. Create a new business entity (NewCo) to deliver IT services in the LHIN, by exploring the best models, and drawing on the expertise found in the IT departments of Northeastern hospitals.

3. Establishing a regional Enabling Technologies Governance Group that includes hospitals and other system partners to set digital priorities for the region.

All 24 acute-care hospital Boards have committed to work together to achieve this goal.

PHYSICIAN UPDATE

Dr. Theal, Chief Medical Information Officer and a staff Gastroenterologist at North York General Hospital (NYGH) attended our MAC meeting to have a high-level discussion around clinical standardization and its effect on Quality Care in the organization

Dr. Theal also attended our April Grand Rounds session to highlight the importance of electronic clinical standardization for the patient, clinician, and organization

Chief Medical Information Officer (CMIO) session in Sudbury went very well

NEXT STEPS

- Hardware requirements for pared down configuration for Wave 1 hospitals only has been finalized and plan is to order hardware and have it ready for Meditech configuration by Oct 15th
- RFP Process completed but no vendors met the criteria so the RFP was closed
- CMIO's continue to move forward with the clinical order sets and working closely with our third party partner (Zynx) on mapping the vanilla order sets to match North York Regional Hospital
- Planning activities have been completed for both Finance and HR and work will begin again as part of the implementation plan
- Plan to provide board with an update on August 21st to help better understand the regional approach to the HIS Project and get their support moving forward with the project
- Continue to work with Meditech on the contract with the goal to have the contract signed by the end of September assuming board approval is received first
- There are still three activities remaining to be completed and will be by August 31, otherwise all other activities have been completed.
- Plan continues to be that we will begin the implementation phase of the project in December 2017 in partnership with North Bay Regional Hospital and West Parry Sound Hospital with the implementation of Meditech in December 2018.

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External Environmental – Health Human Resources – Ministry of Health and Long Term Care

A focus on enhancing and expanding the skills of the healthcare team, ensuring the right mix of health care providers across the continuum and ensuring the right number and mix of healthcare providers in our LHIN are key elements of the province and the LHIN's health human resources strategies.

Health Force Ontario Strategy

- In May 2006, Ontario launched the Health Force Ontario Strategy to respond to existing critical shortages in health human resources, and it aimed to ensure that existing gaps would not worsen. The Strategy ensures that Ontarians have access to the right number and mix of qualified health care providers, now and in the future. The Health Force Ontario Strategy:
    - Identifies and addresses health human resource (HHR) needs;
    - Engages partners in education and health care to develop skilled, knowledgeable providers and create the health care delivery teams that will make the most of their abilities;
    - Introduces new and expanded roles to increase the number of providers working in health care and build on the skills of those already in the system; and
    - Makes Ontario the employer-of-choice for all health care providers.

Registered Nurses and Registered Practical Nurses

- The Ontario College of Nurses is reporting a 2016 membership of 104,140 Registered Nurses which is a slight decrease from the 104,401 in 2015.
    - It reports that 96,004 are currently employed in Ontario.
    - 66.2% are full-time (63,591)
    - 26.3% are part-time (25,239)
    - 7.5% are casual (7,174)
    - 61% of Registered Nurses are working in a hospital, 20% in Community, 9% in LTC, 10% Other
- Registered Practical Nurses membership increased from 44,195 in 2015 to 46,888 in 2016.
    - 41,506 are currently employed in Ontario.
    - 54.2% are full-time (22,478)
    - 36.3% are part-time (15,084)
    - 9.5% are casual (3,944)
    - 36.3% are working in a hospital, 19.9% in Community, 39.7% in LTC and 5% in Other

Total membership

	2014	2015	2016
RN	104,298	104,401	104,140
RPN	42,018	44,195	46,888
NP	2,362	2,567	2,822
Total	**148,678**	**151,163**	153,850

Physicians

- Effective August 31, 2015, Mr. Tom Magyarody took up his appointment of Chief Executive Officer of the Ontario Medical Association replacing Mr. Ron Sapsford who retired. Mr. Magyarody has previously served as the CEO and Executive Director of the Ontario Dental Association.
- As of January 2017, there are 83,159 active physicians (excluding residents) in Canada. These numbers have increased consistently and have outpaced the growth of the Canadian population in recent years.
- Physician mix
    - 52% are family physicians; 48% are specialists of other disciplines.
    - 40% (32,883) are aged 55 or older.
    - 41% are female; 59% are male. Two thirds (64%) of family physicians under age 35 are female.
    - 75% graduated from a Canadian medical school, 22% graduated from a foreign medical school, 3% not stated.
- Physician distribution
    - Less than 8% of physicians practice in rural areas whereas about 19% of Canadians live in rural areas. The figure for family physicians is 14% compared to 2% of specialists.
    - There is a higher concentration of foreign medical graduates in Saskatchewan (53% of all physicians) and Newfoundland (38%) than in provinces such as Quebec where only 9% graduated outside Canada.
    - 74% of Canadian graduates practice in the province where they graduated. Graduate retention figures range from 39% in Nova Scotia to 85% in Quebec.
- Physicians in Training
    - First year enrolment in undergraduate medical schools in 2015/16 was 2,919. This is an 85% increase since 1997/98.
    - 53% of first year medical students in 2015/16 were female; 47% were male.
    - Total enrolment in 2015/16 was 11,685; number of graduates in 2016 was estimated at 2,853.
    - Number of residents in postgraduate programs in 2015/16 was 16,200. Of these, 12,841 were Ministry-funded positions (3,370 at PGY-1); 1,867 were International Medical Graduates (IMGs) and 10,974 were Graduates of Canadian Medical Schools (GCMSs).
    - The practice entry cohort in 2015 was 3,204. This excludes visa trainees and re-entry trainees.
- CARMS match
    - In 2016 there were 2,833 GCMS matched to residency positions.
    - 92% of GCMS participating in the match got one of their top three choices in the first iteration.
    - 36.2% of Canadian grads made family medicine their first choice.
    - There were 1815 IMGs (excluding IMGs from the USA) participating in the match (mostly in a parallel process). By the end of second round, 408 had Ministry funded residency positions.
- Physician Migration
    - 162 physicians moved abroad in 2015. In the same year, 272 returned from abroad for a net gain of 110.
    - 739 physicians moved to another province/territory in 2015 (excl. residents). Net gains occurred in PE(2), QC (10), MB (3), SK(3) and BC (38).
- International comparison
    - Canada has 2.6 physicians per 1,000 population (including residents) compared to the Organization for Economic Co-operation and Development (OECD) average of 3.3 (2014 or nearest year).
    - Canada's phys/pop ratio ranks 28 out of 35 nations ahead of the US, Japan, Poland, Mexico, Korea, Chile and Turkey.

Physicians Ontario

- In 2017, there were are 29,898 physicians working in Ontario, with 14,690 being family physicians, and 11,456 being specialists
- 2,471 of those physicians are under the age of 35
- 6,976 are between the ages of 35 and 44
- 7,345 are between the ages of 45 and 54
- 7,044 are between 55 and 64.
- 5,095 are over the age of 65

Physician Services Agreement

- After voting down a proposal that would have increased the approximately $12-billion physician services budget by more than $1 billion but also included $200 million in fee cuts, in June 2017 physicians voted in favour of a deal that will send contract disputes with the government to binding arbitration.
- Ontario's physicians, who have been without a contract since March 31, 2014.
- The Ontario Medical Association, which has about 44,000 members, says the vote was 65 per cent in favour of the deal that determines how the physicians' next contract, and all subsequent contracts, will be settled.
- First there will be an effort at negotiation, and if a deal isn't reached, they'll go to mediation and then binding arbitration. Binding arbitration is used to set physician compensation in seven other provinces and the Northwest Territories, but Ontario's government had rejected the physicians' demand until earlier this year.
- OMA supported the final agreement, but some independent physician groups had urged physicians to vote it down, saying it doesn't go far enough.
- Under the new deal, how cost overruns are dealt with will be negotiated.

Regulated Health Professionals

- Effective July 1, 2015, the College of Naturopaths of Ontario has been established under the Regulated Health Professions Act, 1991.
- Health care professionals outside medicine are increasingly expanding their scope of practice. Nurse Practitioners in Manitoba can order diagnostic tests. In Ontario, paramedics have enhanced roles in providing home care services for seniors and pharmacists can now administer vaccines. New health professionals such as physician assistants have been introduced in Manitoba, Ontario, New Brunswick and Alberta.

Funding and incentives

- On June 15, 2017, the MoHLTC announced that Physician Assistant (PA) Career Start grants to employ Ontario's 2017 PA graduates were available.
- Financial support of $46,000, depending on geographic location, will be provided to help approved employers provide PA graduates with employment opportunities.
- An additional $10,000 is being offered as an incentive for PAs who accept positions in rural and/or northern geographies.
- Opportunities for 2017 Ontario PA graduates will be supported in priority settings including Emergency Medicine, Primary Care, General Internal Medicine (inpatient), and other clinical settings, to help address patient care needs.

Wages, compensation and benefits

- Rising costs of extended health care benefits continue to be a concern to hospitals.

- Major Canadian group insurance carriers to provide the annual inflation factors they are using to project health and dental claim costs for the upcoming year in the pricing of their premium rates. They then compared these factors to

those provided in previous surveys in order to get a sense of the long-term health care pricing trends for group insurance plans.

- The insurers provided information with inflation factors for each type of coverage:
    - prescription drugs,
    - medical, and
    - hospital.

- The factors account for the insurer's expected increases in claims resulting from the following:
    - Cost inflation
    - Increases in utilization of services
    - New services and products entering the market
    - Legislative changes
    - Changes in the mix of services
    - Shifting costs from the public to the private sector

- Continuing with last year's slight increase in inflation factors for all of components of health care, this year the overall trend in cost increases again showed a slight increase. Looking at all of the health care components on a blended basis, insurers are using an average trend factor 11.81%, up from 11.69% last year.

- With prescription drug costs representing the majority of private payer health spend, they have the greatest influence on employer benefit cost trends. Insurer's inflation factors for prescription drugs demonstrate an increase from 11.57% in 2015 to 12.09% for 2016.

- Hospital inflation factors have been consistently on the upswing from 2011 to 2014, however beginning in 2015, there was a drop in the magnitude of the increase. The decrease continued again in 2016 with the insurer trend reducing from 9.70% in 2015 to 7.41%. Expected utilization trend of dental services has decreased slightly from 5.93% in 2015 to 5.86% this year.

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External Environment – Communications

Health care decisions have great impact on the communities we serve; the smallest of change can create substantial effects throughout our organization, the community and within our partner organizations.

Ensuring we have a communications strategy that closely aligns to our strategic focus and our Mission will provide us with the opportunity to engage our community, our partners, and our organization as an active partner in the best community health care system in the country.

Sault Area Hospital is committed to embracing the patient centred care model and our current Communications and Community Engagement Plan will help support our initiatives. Our Plan will endeavour to build strong partnerships and establish open collaborative communications with the people affected or impacted by our plans – our patients – our families – our people.

- Community perceptions about Sault Area Hospital (SAH) are significantly impacted not only by personal experience but, also by word of mouth, media stories and social media commentary; including comments/opinions expressed by our own staff.
- SAH developed a communications strategy that focuses on improving community perceptions through community education and by continuing to leverage our internal audience to help build our brand.
- Over the past several years SAH has been able to develop strong working relationships with our traditional media partners.
- Future focus of SAH's communication strategy is to become more proactive in our approach to community messaging and education through the use of traditional strategies, established media partnerships and social media.
- In addition, as a requirement of the *Local Health System Integration Act, 2006 (LHSIA),* Sault Area Hospital is required to "engage the community of diverse persons and entities in the area where it provides health services when developing plans and setting priorities for the delivery of health services".

Media Relations

- Involves working with media for the purpose of informing the public of an organization's mission, policies and practices in a positive, consistent and credible manner. Typically, this means coordinating directly with the people responsible for producing the news and features in the mass media. The goal of media relations is to maximize positive coverage in the mass media.
- Relationship Building with our Media Partners:
    - Provides the local perspective on health care stories;
    - Highlights SAH's Areas of Expertise;
    - Improves the patients experience through education; and
    - Provides staff, physicians, and volunteers with the opportunity to see their work highlighted to our community.
- Proactive use of Media
    - Allows SAH to engage with our media partners to improve SAH's public perception through planned and targeted education.
- Risks Associated with Media Relations
    - Online media coverage and social media has shortened the story turn-around time for news outlets. Being unable to respond within deadlines opens SAH to potential reputational risk.
    - SAH has the opportunity to further develop our media relations program to allow us to respond to inquiries within this new reality by providing our leadership team with general and crisis media training; also
    - By creating a pool of subject matter experts that could be called upon for specific subject inquires.

Social Media

- Social media refers to collaborative and interactive online communication and community building tools (change foundation).
- Benefits of using Social Media for SAH:
    - Improves loyalty, trust and confidence in our organization; we will be seen as accessible, approachable and current;
    - Establishes SAH as a health care authority and as a health care leader;
    - Strengthen brand awareness;
    - Captures public sentiment on health topics and correct misinformation;
    - Increases interactions and build relationships with others, including the public and partners;
    - Improves reach and accessibility;
    - Increases community and public access to health information;
    - Influences policy and opportunities for advocacy;
    - Provides a means to communicate and respond in an emergency; and
    - Educates and raises awareness on a breadth of health care topics and activities.
- As of 2016, SAH is now engaging in the use of two social media platforms – Facebook and Twitter. The inclusion of social media as a tool for our communication strategy has allowed SAH to share our story from our prospective by featuring our successes and highlighting our people.
- Future development of social media usage for SAH:
    - Reputation and social media – Monitoring social media for issues important to your patients and community is good practice not only for reputational risk management but, more importantly, as a potential source of ideas to improve services and an opportunity to measure public sentiment as part of quality improvement processes.
    - Quality improvement culture that moves beyond simply monitoring social media – and actively listens, acts on patients' ideas and concerns and communicates back to the public on actions taken – can build or reinforce a positive reputation.

Internal Communications

- Is the sharing of information across the entire organization; it is meant to be two-way communication that ensures the flow of information to employees, physicians, and volunteers.
- Goals for SAH Internal Communications:
    - Improve employee, physician, and volunteer engagement through information shared by:
        - Recognizing accomplishments;
        - Profiling staff, physicians, and volunteers;
        - Promoting improvements and successes at SAH; and
        - Informing staff, physicians, and volunteers of decisions and changes.
    - Encourage active involvement in SAH communications.

Public Relations

- The aim of public relations is to inform the public, partners, employees, and other stakeholders and ultimately persuade them to maintain a certain view about the organization, its leadership and services.
- Public Relations opportunities for SAH:
    - Create positive awareness of the many success stories at SAH, focusing on our exceptional people, working together and outstanding care, through:

- Use of social media | Website | SAH Annual Report | CEO/Board Chair Speakers Circuit | Sault Star Column | Editorial Opportunities - BLOG | NOMJ | Digital Signage | Electronic Marquee | Corporate Newsletter
- Proactive Public Relations – Allows SAH to control the messaging to the public providing an opportunity to highlight success and impact public perceptions.
- Risks Associated with Public Relations – Public backlash to information shared. SAH needs to plan ahead for any potential unfavorable response.

Patient and Family Engagement

Patient and Family First Culture - Involving patient and family advisors in key decisions in the organization, ensuring patients and their families have timely access to information and can have their questions answered and seeing patients and their families as part of the health care team. (Priority Initiative SAH Strategic Plan 2016 – 2021)

- In 2010, The Excellent Care for All Act (ECFAA) became law with the mandate of putting Ontario's patients first by strengthening the health care sector's organizational focus and accountability. The ECFAA sets out a number of requirements for health care organizations. One specific requirement is that hospitals "establish a patient relations process to address and improve the patient experience." One model that institutions were already using and is gaining popularity across hospitals in Ontario is the Patient and Family Advisory Council." (The Change Foundation, Patient/Family Advisory Councils in Ontario Hospitals).
- The aim of patient and family engagement at Sault Area Hospital is to show commitment to:
  - Improve care for all patients and family members at Sault Area Hospital by ensuring that the patient is the focal point of all discussions
  - Contribute ideas and suggestions that will enhance patient and public involvement in health service planning and decision-making so that the patient has a voice in the delivery of health care services
  - Promote improved collaboration and relationships between patients, families, and staff
  - Improve the experience of patients and families when interacting with SAH
- This commitment is shown through:
  - Maintaining corporate SAH-PFAC meetings on a bi-monthly basis
  - Maintaining patient and family advisory councils for key SAH program areas:
    - Algoma District Cancer Program
    - Algoma Regional Renal Program
    - Mental Health and Addictions
  - Introducing report outs occurring on the off meeting month (Fall, Winter, Spring)
  - Enhancing supportive resources for advisors and staff
  - Increasing support for advisors working on ad-hoc projects
  - Increasing support for advisors working on committees
  - Increasing support for staff working with advisors
  - Improving evaluation framework around advisor engagement

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External Environment – Service Utilization – Medicine

As patients live longer, with greater incidence of chronic illness, the use of hospital and health care services will increase.

Patient Population

- Given the role of the Medical Program within SAH, providing medical care to those with unexpected illness or injury, the demographics of the region that will impact volume in these areas include:
  - Higher proportion of seniors;
  - Higher proportion of Aboriginals (increased rates of diabetes and cardiac disease);
  - Higher rates of cardiac disease, diabetes, asthma and hypertension;
  - Higher incidence of some cancer (lung, breast);
  - Higher incidence of unhealthy lifestyle indicators (obesity, smoking, drinking), which contribute to chronic disease; and
  - The Baby Boom will double the number of seniors living in Ontario over the next 20 years. Nearly a quarter of Canadians is likely to be over the age of 65 by 2031.

Resources

- As patients live longer, with greater incidence of chronic illness, the use of hospital and health care services will increase. Combined with insufficient community resources to support long-term care, supportive housing and community health care as well as reduced availability of primary care and extended family to provide care to elderly and infirmed people, the rates of hospitalization will increase without significant investment in outpatient health care and community support. This will continue to have a significant impact on acute care bed availability without a change in the community resources.
- Recruitment and use of physicians/other care providers to support medical care will continue to be necessary to address staffing level issues.

Technology

- The rate of technology has increased substantially in health care over the past few years, both in patient care equipment and automation of records. In order to continue to improve efficiency (due to rising cost of health care), technology investments will be necessary to support hospital care.
- Point of Care testing (e.g. measurement of common blood tests such as blood sugar) to improve accessibility, turnaround time.
- Implementation of business solutions to consolidate the tremendous amount of patient and performance data currently being collected.
- In order to offer “standard of care” treatment to patients, investments will need to be made in types and scopes of services available (e.g. Cardiac intervention services – SAH is currently the only Ontario site that provides cardiac diagnostic services but no treatment, necessitating transfer to other centres).
- The trend toward regional care will continue dictating changes to processes and levels of care at SAH based on a standardized approach for all centres in the North East Local Health Integration Network (NE LHIN). Regional (LHIN-based) steering committees have been struck related to Stroke Care, Rehab and Complex Continuing care to implement recommendations around the region in these areas (e.g. defining use of beds and admission criteria, monitoring access, wait time and performance metrics).
- Changes implemented as a result of this work will result in opening of our ‘borders’ in order to accept and provide care to patients from anywhere within the entire LHIN in these areas.

The Community Care Access Centre (CCAC) is an active partner in both these steering committees, as well as planning the delivery of community services to support discharge (e.g. Integrated Discharge services). This partnership will need to continue to grow to support the move from 'hospital to home' in a timely manner.

External Environment – Service Utilization –Rehab and Complex Continuing Care

As patients live longer, with greater incidence of chronic illness, the use of hospital and health care services will increase.

Discussion

Despite hospitals' best efforts, continued ALC challenges in the Northeastern region coupled with new aggressive province-wide targets of 9.46% ALC in acute care and 12.7% ALC in combined acute and post-acute settings point to the need for renewed focus on ALC across the NE LHIN. Sault Area Hospital (SAH) has taken this opportunity to "re-think" ALC and identify key system and process improvement levers to work towards the provincial targets over the next three years.

SAH and our Community Care Access Centre (CCAC) have adopted the ALC Avoidance Framework

1. Leading practices with other NE LHIN hospitals as a key process improvement initiative for the NE Patient Flow Strategy: Improving Care Coordination and ALC Performance.

2. With NE LHIN Nurse Leaders, the hospitals have developed ALC avoidance work plans that are based on the ALC Avoidance Framework self-assessment results and informed by intra-organizational and community partner consultation.

By focusing on complex frail older adults, significant strength can be derived from the corresponding alignment of inter-related system priorities. While directly aligned to SAH's Strategic Plan, the identified ALC avoidance priorities for 2017/18 concurrently integrate the Senior Friendly Hospital Framework3, Assess & Restore Collaborative best practices, and Rehabilitative Care Alliance Framework bedded levels of care requirements.

Action

Table 1:
Direct ALC Impact from 2A opening (January 23/17)

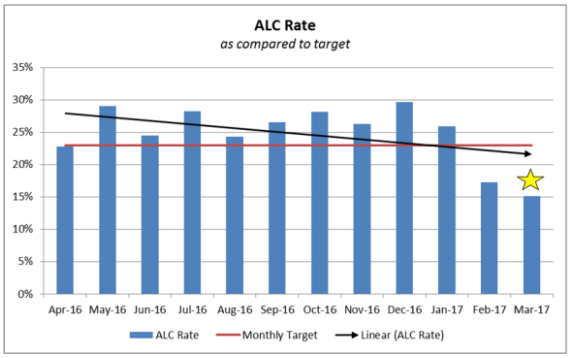
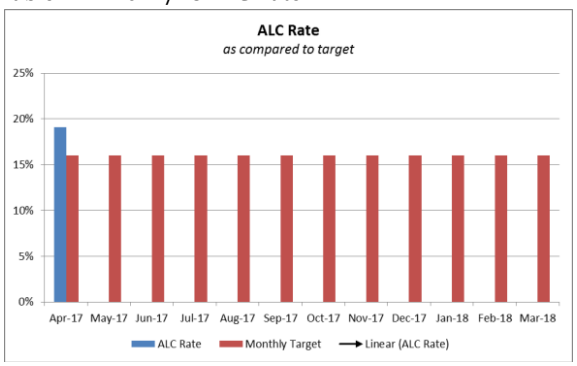


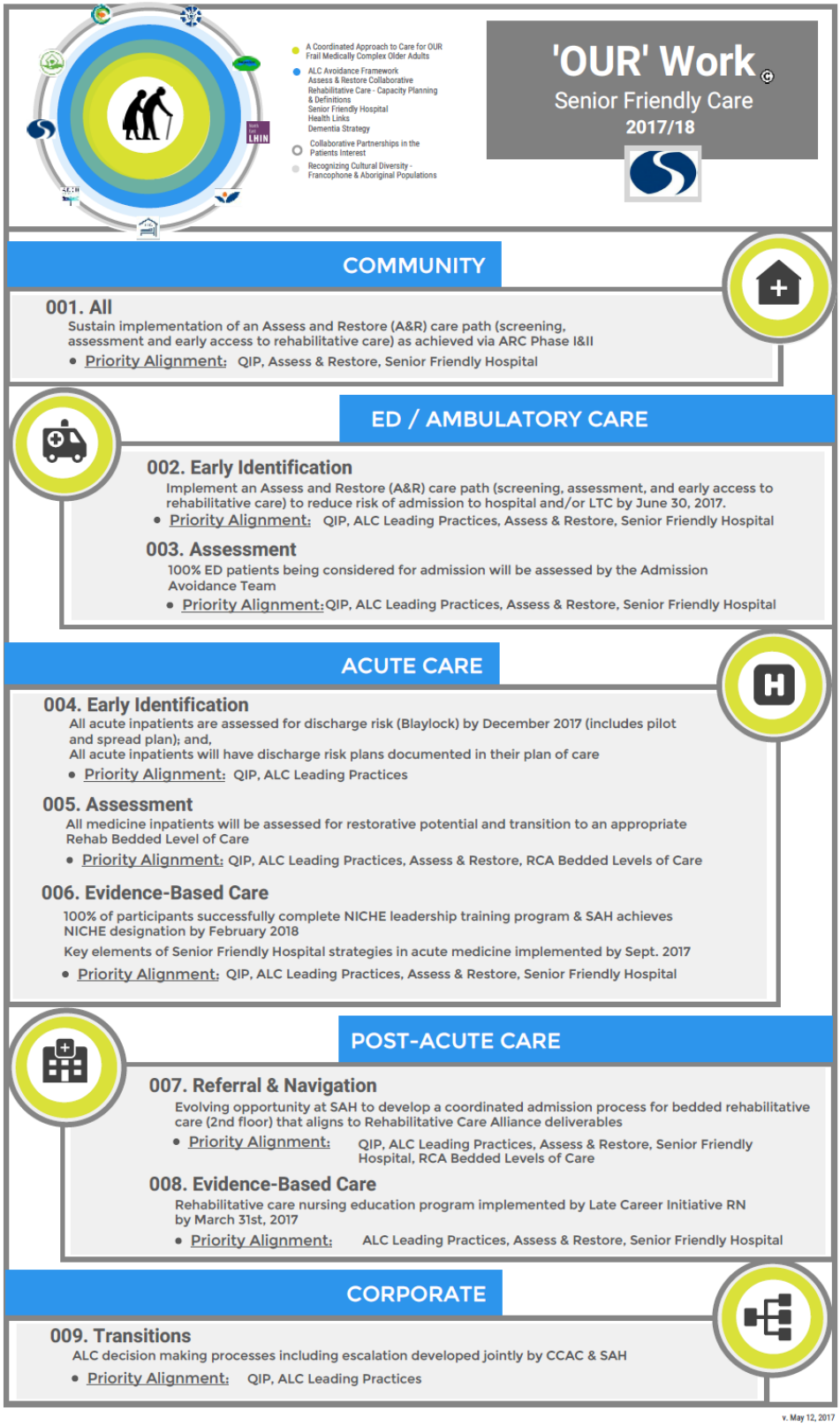
Table 2: FY2017/18 ALC Rate



'Our Work' 17/18

With system focus on senior-friendly hospital care and identifying opportunities for sustainable alternate level of care practices, our work has enabled new teams, new work flow and new patient and family involvement in care transitions to match the patient's care needs and their rehabilitative potential to return home. This innovative approach to managing multiple aligned system priorities has gathered strength across the organization to commit to complex change management in the patient's interest. The following table outlines the work plan and goals for 2017/18:

‘Our Work’ – Senior Friendly Care Infographic 17/18



External Environment – Service Utilization – Oncology

A lot of progress has been made in cancer care in recent years. Policies related to prevention, such as smoking restrictions, are in place. Screening programs allow colorectal, breast and cervical cancers to be found at an earlier, more treatable stage (or even prevented in some cases). And new, more effective treatment continues to be developed. Yet, cancer continues to place a tremendous burden on individuals, caregivers and the healthcare system.

Forty-five per cent of men and 41 per cent of women in Ontario will develop cancer in their lifetime. The number of new cases of cancer is rising and is expected to continue to rise into the foreseeable future. The aging population is a significant factor in the growth of new cancer cases, as cancer is largely a disease of aging.

In high-income countries similar to Canada, an estimated 40 to 50 per cent of cancers are associated with behavioural, occupational and environmental risk factors, and could be prevented. In light of the growing and aging population, initiatives that target modifiable risk factors take on added importance.

Discussion

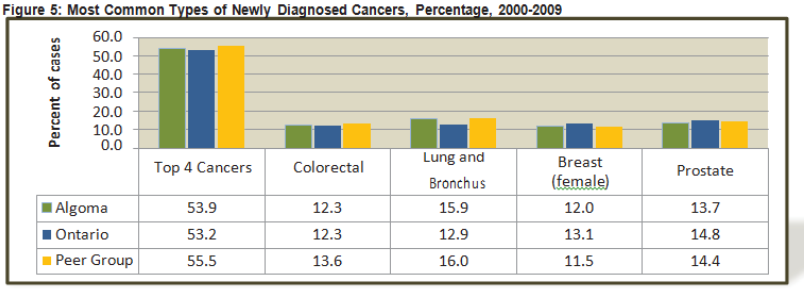
- In Algoma, there were 7,534 newly diagnosed cases of cancer in the 15 to 75+ age groups between 2000 and 2009, an average of 753 people per year.
- In Ontario, 591,606 people were diagnosed with cancer, an average of 59,160 people per year. During this 10-year timeframe, Algoma's newly diagnosed cancer cases accounted for 1.3% of all new cases in Ontario.
- Algoma mirrors the Canadian picture in that the top four cancers also account for over half of all newly diagnosed cancers.

The most common types of cancer in the Algoma District:

- Prostate, Breast, Lung and Colorectal
- According to the Canadian Cancer Society (CCS), these four cancers account for over half (52.0%) of all newly diagnosed cancers in Canada. In Algoma, these four cancers accounted for 53.9% of all newly diagnosed cases, 53.2% of cases in Ontario, and 55.5% of cases in our Peer Group.
- Algoma's age standardized rate for all cancers, between 2000 and 2009 was 427.6 per 100,000 people compared to Ontario's rate at 410.2 per 100,000 people and our Peer Group at 439.5 per 100,000 people. Algoma's rate was statistically higher than the Ontario rate but not statistically different from our Peer Group.

Prostate cancer in men accounted for 13.7% of all new cancer cases in Algoma, compared to 14.8% of cases in Ontario and 14.4% of cases within our Peer Group. Breast cancer in women accounted for 12.0% of all new cancer cases in Algoma, compared to 13.1% in Ontario and 11.5% in our Peer Group. Colorectal cancer accounted 12.3% of all new cancer cases in Algoma, similar to Ontario at 12.3% and lower than our Peer Group at 13.6%. Lung and bronchus cancer accounted for the greatest proportion of new cancer cases in Algoma at 15.9%, compared to Ontario at 12.9% and our Peer Group at 16% (Figure 5).

Figure 5: Most Common Types of Newly Diagnosed Cancers, Percentage, 2000-2009



	Top 4 Cancers	Colorectal	Lung and Bronchus	Breast (female)	Prostate
Algoma	53.9	12.3	15.9	12.0	13.7
Ontario	53.2	12.3	12.9	13.1	14.8
Peer Group	55.5	13.6	16.0	11.5	14.4

Data Source: Cancer Care Ontario – SEER*Stat Release 9 – OCRIS (May 2012)

Lung and Bronchus

- The age standardized incidence rate for lung and bronchus cancer in Algoma between 2000 and 2009:
- 64.7 new cases per 100,000 people, with the Ontario rate at 52.5 new cases per 100,000 people and our Peer Group at 68.6 new cases per 100,000 people. Algoma's rate was statistically higher than the Ontario rate but not statistically different than our Peer Group.

Urinary Bladder

- The age standardized incidence rate for urinary bladder cancer in Algoma between 2006 and 2009:
- 16.7 new cases per 100,000 people, with the Ontario rate at 12.2 new cases per 100,000 people and our Peer Group at 13.0 new cases per 100,000 people. Algoma's rate was *statistically higher* than the Ontario rate but not *statistically different* from our Peer Group.

Kidney and Renal Pelvis

- The age standardized incidence rate for kidney and renal pelvis cancer in Algoma between 2000 and 2009:
- 12.6 new cases per 100,000 people, with the Ontario rate at 10.4 new cases per 100,000 people and our Peer Group at 12.9 new cases per 100,000 people. Algoma's rate was *statistically higher* than the Ontario rate but not *statistically different* from our Peer Group.

Esophageal

- The age standardized incidence rate for esophageal cancer in Algoma between 2000 and 2009:
- 6.2 new cases per 100,000 people, with the Ontario rate at 4.1 new cases per 100,000 people and our Peer Group at 4.9 new cases per 100,000 people. Algoma's rate was statistically higher than the Ontario rate but not statistically different from our Peer Group.

Algoma's rates were statistically lower for 2 types of cancers.

Prostate

- The age standardized incidence rate for prostate cancer in Algoma between 2000 and 2009 was 118.0 new cases per 100,000 males.
- With the Ontario rate at 134.4 new cases per 100,000 males and our Peer Group at 134.1 new cases per 100,000 males. Algoma's rate was statistically lower than the Ontario rate and our Peer Group.

Liver

- The age standardized incidence rate for liver cancer in Algoma between 2000 and 2009 was 2.3 new cases per 100,000 people.
- With the Ontario rate at 3.7 new cases per 100,000 people and our Peer Group at 2.6 new cases per 100,000 people. Algoma's rate was statistically lower than the Ontario rate but not statistically different from our Peer Group.

Algoma's cancer mortality rate is higher than the Ontario rate

- The age standardized mortality rate for all cancers in Algoma between 2000 and 2009 was186.3 deaths per 100,000 people.
- With the Ontario rate at 165.3 deaths per 100,000 people and our Peer Group at 188.6 deaths per 100,000 people. Algoma's rate was statistically higher than the Ontario rate but not statistically different from our Peer Group.

Algoma's lung and bronchus mortality rate is higher than the Ontario rate

- The age standardized mortality rate for lung and bronchus cancer in Algoma between 2000 and 2009 was 52.1 deaths per 100,000 people.
- With the Ontario rate at 41.4 deaths per 100,000 people and our Peer Group at 54.1 deaths per 100,000 people. Algoma's rate was statistically higher than the Ontario rate but not statistically different than our Peer Group.
- The risks for developing the leading types of cancer can be reduced by making healthy lifestyle choices.
- Not smoking and avoiding exposure to second hand tobacco smoke will reduce the risk of lung and bronchus cancer.
- Eating healthy food and limiting alcohol will help reduce the risk for colorectal cancer.

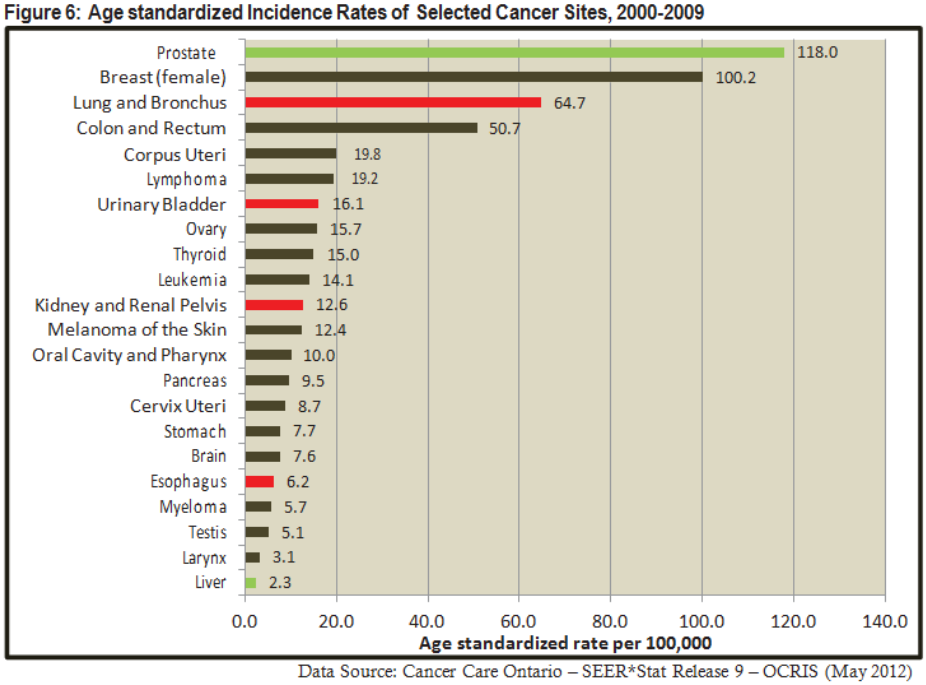
Access to Care & Wait-time Strategy

- Cancer Surgery Wait Times have steadily improved since the province first began to publicly report wait times in August 2005.
- As a result of this strategy, the province has the first ever system to measure, monitor and manage cancer surgery wait times.
- Ontario's wait time strategy has funded over 12,000 incremental cancer surgeries over the last three years. Most Cancer Surgery Agreement (CSA) hospitals have attained a 90% level of performance with regard to the number of cancer surgeries completed.

Mortality Rate

- Cancer was the second leading cause of all mortalities in the Algoma District between 1998 and 2007.

Figure 6: Age standardized Incidence Rates of Selected Cancer Sites, 2000-2009



Data Source: Cancer Care Ontario – SEER*Stat Release 9 – OCRIS (May 2012)

	NOT statistically different from Ontario rate
	Statistically LOWER than Ontario rate
	Statistically HIGHER than Ontario rate

External Environment – Service Utilization – Oncology: Cancer Care Ontario Strategic Priorities 2015-2019

As the cancer advisor to the government of Ontario, Cancer Care Ontario (CCO) is committed to improving the performance of the cancer system by driving quality, accountability, innovation and value.

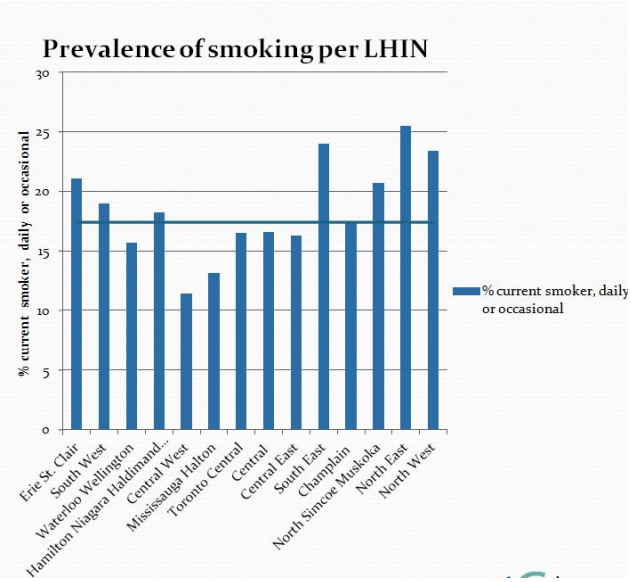
The Ontario Cancer Plan IV for 2015-2019 provides a comprehensive road map for the way CCO healthcare professionals and organizations, cancer experts and the provincial government will work together to develop and deliver cancer services over the next four years.

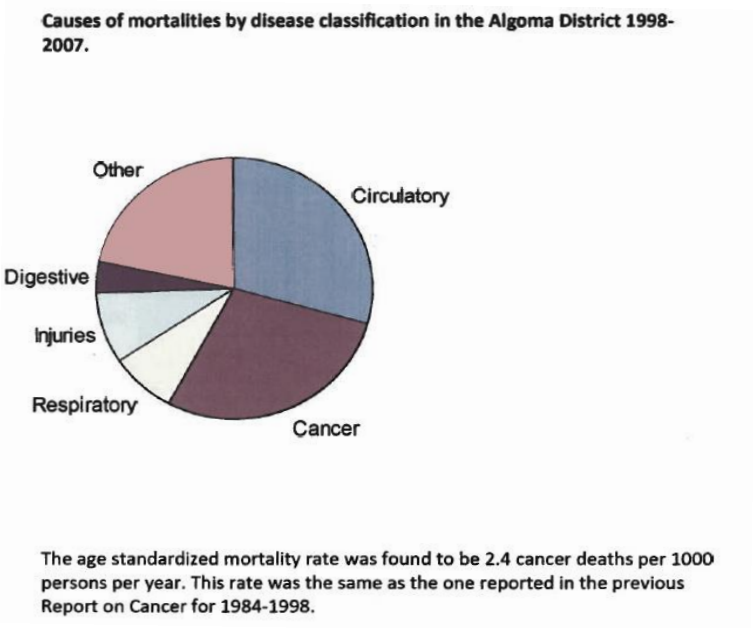
Goal One: Quality of life & patient experience

- Ensure the delivery of responsive and respectful care, optimizing individuals' quality of life across the cancer care continuum.

Strategic Objectives:

- Drive excellence in the development of policies, programs, strategies and evaluation by partnering with patients and their families to ensure services and care reflect their needs and preferences.
- Expand and integrate access to palliative, psychosocial and rehabilitation services to improve quality of life and patient experience in cancer centres and the community.
- Capture a range of real time patient-reported information that is meaningful to patients to improve the quality of care.
- Increase understanding of wait times from the patient's perspective and identify opportunities to improve the patient experience.
- Support healthcare providers, patients and families with training, tools and resources to improve communication decision-making, self- management and quality of life.





By 2019

- Patients will report that cancer care was delivered in a manner that recognized their needs and preferences.
- Patient needs for palliative care and advance care planning will be addressed early in the cancer care continuum. Patients will have timely access to psychosocial and palliative care as appropriate.
- Patients will have opportunities to report on their symptoms for specific disease sites in real time and will have their symptoms addressed.
- There will be improved information and communication resulting in a better experience for those waiting for care.
- Patients and their families will have access to the resources, tools, knowledge and support they need to help them manage their care.
- Patients will have discussions with their provider about advance care planning and will have the information they need to make informed decisions.

Goal Two: Safety

- Ensure the safety of patients and caregivers in all care settings

Strategic Objectives:

- Expand the use of technologies and tools for providers that drive adherence to evidence-based guidelines across care settings, including the home.
- Develop and implement patient safety tools in collaboration with patients and families that enable safer care in settings outside the hospital, including the home.
- Identify opportunities for system level oversight for safety related to cancer services.
- Advance peer review of care plans to ensure concordance with evidence-informed practice and appropriateness of care that will lead to improved patient safety and clinical effectiveness.
- Describe cancer-specific requirements for regulated healthcare providers delivering cancer care.

By 2019

- Concordance and compliance with evidence-based safety guidelines will be increased.
- Patients and providers will be partners in designing how chemotherapy is delivered safely in the home.
- All care partners, including patients and families, will have access to the resources that are needed to ensure a safe care environment, in all settings.
- Following review of reported near-miss and actual incident data, Cancer Care Ontario and our partners will have identified targeted improvement initiatives.
- An accountability framework and performance management structure will be in place to drive improvement in quality and safety in colonoscopy, mammography and pathology.
- In radiation, pathology and mammography, provider peer reviews will be consistently conducted as part of clinical practice.
- Healthcare providers involved in the delivery of chemotherapy, including in the community, will be appropriately trained in oncology care.

Goal Three: Equity

- Ensure health equity for all Ontarians across the cancer system

Strategic Objectives:

- Develop and implement the third Aboriginal (FNIM) Cancer Strategy, building on successes of previous FNIM cancer strategies as well as the established relationship protocol agreements between CCO and FNIM communities.
- Assess, expand, enhance and utilize data to better understand and improve equity issues in the regions.
- Develop locally relevant policies and programs in partnership with community service providers to improve access to services for specific populations and support healthcare providers with training, data and tools to deliver equitable services.
- Advise governments in the development of provincial policies and programs to improve access to services for specific populations, including equitable access to specialized services.

By 2019

- The relationships among First Nations, Inuit and Metis (FNIM), CCO and Regional Cancer Programs will be firmly established and formalized through protocols. This will ensure and sustain ongoing dialogue and implementation of the Aboriginal (FNIM) Cancer Strategy through customized regional Aboriginal cancer plans, an achievement that will allow for increased service awareness and equitable access that honours the Aboriginal path of well-being.
- FNIM identifiers will be incorporated into data sets that will be used to detect and quantify equity gaps
- Data to identify equity gaps will be available beyond FNIM populations, including “cancer risk profiles” for communities.
- CCO will provide the information and tools that will support the Regional Cancer Programs in reducing disparities that exist in prevention, care and outcomes.
- Equity assessments will be applied to program design to ensure that access and utilization of services by FNIM and other underserved, high-risk communities are improved.

Goal Four: Integrated Care

- Ensure the delivery of integrated care across the cancer care continuum

Strategic Objectives:

- Stratify patients by risk, based on clinical factors, comorbid conditions and social determinants of health, to determine the supports that patients and families require to navigate their care pathway.
- Ensure that standardized care plans are developed and communicated to all members of the care team, across the cancer care continuum, to facilitate an integrated approach to care that is centred on the patient.
- Enhance communication among all providers across the cancer care continuum and care settings to facilitate smoother care transitions.
- Increase the availability of relevant patient clinical information to patients and providers across care settings to support informed decision-making.
- Determine opportunities for improving the transition of adolescent and young adults, when appropriate, from the pediatric to adult cancer care system.

By 2019

- Patients will have appropriate supports throughout their care pathway, and providers will have the necessary tools to assist their patients with navigation.
- Standardized care plans will be available for selected disease sites, treatments and patient populations, across care settings. These plans will be used to improve communication of goals of care and expected outcomes among patients, families and providers.

- Use of technology will be expanded to improve communication among providers across the cancer care continuum and care settings.
- Patient care information is made available to patients and providers to support joint decision-making (e.g., Diagnostic Assessment Program – Electronic Pathway Solution and Interactive Symptom Assessment and Collection).
- A strategy will be developed with provincial partners to improve transitions for adolescents and young adults.

Goal Five: Sustainability

- Ensure a sustainable cancer system for future generations

Strategic objectives:

- Develop and execute on a chronic disease prevention strategy, which focuses on reducing the incidence of the major chronic disease modifiable risk factors and exposures.
- Continue to implement organized cancer screening programs for breast, cervical and colorectal cancer.
- Assess value from a patient experience, population health and cost perspective to inform decision-making across the cancer system.
- Optimize the model of care delivery to achieve the greatest benefit for patients and the cancer system.
- Strengthen and expand system capacity planning to ensure resources are most optimally allocated and utilized.

By 2019

- We will have begun implementation of the chronic disease prevention strategy and have developed the evaluation framework.
- Participation in breast, cervical and colorectal cancer screening programs will be increased and follow-up for those with an abnormal screening result will be improved.
- Drugs funded through the Provincial Drug Reimbursement Program will be evaluated for the greatest benefit to patients and impact on healthcare resources.
- Innovative, person-centred models of care will enable the right provider to deliver the right care, at the right time, in the right place.
- Data-driven, system-level plans will be used to allocate key health human, infrastructure and financial resources for all cancer services.
- Radiation, gynecology, and medical oncologist positions will be expanded consistent with capacity planning models.

Goal Six: Effectiveness

- Ensure the provision of effective cancer care based on best evidence

Strategic Objectives:

- Expand measurement of outcomes to enable effective, high-quality care.
- Expand our performance management model to include non-hospital healthcare organizations and performance at the provider level in order to be more effective with our quality and access programs across the system.
- Leverage and expand the use of evidence-based guidance to improve the appropriateness of care.
- Develop a unifying strategy for personalized medicine for cancer care including personal and tumor genetics and incorporate recommendations into clinical practice.

By 2019

- Standards, guidelines and programming for patient care will be informed and developed using enhanced measures of clinical and patient-reported outcomes for colorectal and breast cancers.
- We will use system-level indicators to compare the performance of Ontario's cancer system against international benchmarks.
- Our performance management and evaluation system will be expanded beyond the hospital setting
- Individual healthcare providers and facilities will have access to performance data to drive improvements in care.
- Our funding levers will be used to align care with evidence-based guidelines for mammography, upper gastrointestinal endoscopy, colonoscopy, colposcopy, systemic treatment, cancer surgery, radiation, diagnostics and other specialized services.
- In conjunction with our partners, we will begin the implementation of the personalized medicine strategy for cancer care in Ontario.

External Environment – Service Utilization – Oncology: Systemic Treatment in Ontario 2014-2019

Following the implementation of the first Systemic Treatment Provincial Plan in 2009, regional systemic treatment programs were established across the province to create a coordinated approach to patient focused care. The first plan helped make improvements in Chemotherapy Standards, Service Planning, Health Human Resources, and a new Systemic Treatment Funding Model, and Quality Person-Centred Systemic Treatment.

Systemic Treatment Provincial Plan 2014-2017 will build on existing strengths and partnerships to consolidate and extend the efforts of the first plan to improve the safety, quality and accessibility of systemic treatment in the province. It focuses on the changing needs of the system, and areas in which quality gaps and opportunities for progress exist.

This plan is guided by two over-arching goals**:**

- Extend the Quality and Safety Agenda
- Strengthen and Enable Care Models

Strategic Priorities:

- Extend the quality and safety focus from parenteral to oral chemotherapy
    - Prescribing
    - Monitoring and Adherence
    - Education
- *Reduce emergency room utilization through enhanced toxicity management*
    - Best Practices
    - Roles and Communication
    - Leveraging Technology
- Ensure consistency in access and quality of chemotherapy delivered in the home
    - Patient Choice and Access
    - Patient Experience, Education and Support
    - Education and Training for Providers
- Ensure standardization of chemotherapy dispensing practices within community pharmacies
    - Prescription Verification
    - Quality and Standardization of Dispensing Practices
    - Continuity and Coordination of Care with Community Pharmacies
- Expand the system's ability to monitor and evaluate the quality of systemic treatment
    - Standardization
    - Safety and Quality Standardization
    - Incident Reporting

- Enhance coordination of care and communication strategies to improve person-centered care
    a. Transitions and Coordination
    b. Decision Making
- Enable new models of care to improve sustainability
    - Patients on Active Treatment
    - Inpatients
    - Complex Hematology Patients
- Strengthen regional capacity to optimize regionally-appropriate delivery of care
    - Regional Structures
    - Provider Education
- Develop and implement patient-based funding model
    a. Funding Model

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Ontario Ministry of Health & Long Term Care

External Environment – Service Utilization – Renal

Chronic Kidney Disease (CKD) is an emerging public health problem in Canada and throughout the world. An estimated 2.6 million Canadians have kidney disease or are at risk. CKD is the presence of kidney damage or a decreased level of kidney function for a period of 3 months or more. CKD can be divided into 5 stages depending on how severe the damage is to the kidneys or the level of decrease in kidney function.

The focus on CKD management from the perspective of the patient is driven by the need to ensure quality across the system by:

- Supporting evidence-based CKD patient care by establishing consistent standards and guidelines for renal care;
- Funding patient-based care to drive equity and access to CKD care; and
- Putting in place information systems to measure performance.

Discussion:

- The Ontario Renal Network (ORN) drives quality, innovation and value in chronic kidney disease system by developing plans built around improving health, improving system accountability and optimizing value for money to achieve a quality, patient-centred approach to care at every stage of the CKD care continuum.
- There is no single cause of chronic kidney disease. Some functions of the disease may be inherited while others are acquired. The two most common causes are diabetes (35%) and high blood pressure (18%).
- Diabetes continues to be the predominant cause of kidney failure in Canada with one in three people with kidney failure being diabetic.
- The number of Canadians being treated for kidney failure has tripled over the past 20 years.
- 53% of new renal failure patients are 65 years of age or older
- Among the 39,352 people being treated for kidney failure in Canada in 2010:
    - 59% were in dialysis; and
    - 41% had a functioning transplant.
- Hemodialysis (HD) is the treatment used in the majority of dialysis cases. It costs roughly $50,000 per patient per year (2016). It is an imperfect therapy with bad outcomes and high costs.
- The one-time cost for a kidney transplant is approximately $23,000, plus $6,000 per year for necessary medication.
- Nearly 80% of the over 4,300 Canadians on the waiting list for organ transplantation are waiting for a kidney.
- Better management of chronic conditions like diabetes will reduce the number of unnecessary hospital visits, resulting in better care and less waste of resources.
- One in three Ontarians has at least one chronic disease. Among those age 65 and over, 80% have at least one chronic disease and of those, 70% have two or more chronic diseases. Chronic disease account for 60% of Ontario's health care expenditure.
- More than half of people with chronic disease eat poorly and are physically inactive. Many continue to smoke, one in four is obese and obesity rates are rising.
- Aboriginal populations are at higher risk than the average population for kidney disease. They require greater medical attention. They typically experience higher rates of chronic diseases and often limited access to care.
- Chronic illnesses are the major drivers of health care costs. Chronic conditions such as cancer and diabetes could cost the global economy $47 Trillion dollars over the next 20 years.

External Environment – Service Utilization – Renal – The Ontario Renal Network Strategic Priorities 2015-2019

Empower and support patients and family members to be active in their care

- Develop and implement standardized tools that enable shared decision-making, encourage self-management, and jointly establish goals of care
- Partner with regional and provincial organizations to strengthen and broaden the use of peer-to-peer support
- Collect and report patient experience and outcome measures for targeted quality improvement
- Develop formal opportunities for patients and family members to be involved in kidney care system initiatives

Integrate patient care throughout the kidney care journey

- Explore and develop safety initiatives and tools to prevent avoidable harm, including acute kidney injury, in primary care and hospital settings
- Develop and implement tools to assist with the early identification and management of people with CKD in primary care
- Establish provincial standards and accountabilities with Regional Renal Programs to streamline the transition between primary care and nephrology, for people with CKD at risk of progression to end-stage kidney disease
- Define and implement a model of care that supports comprehensive delivery of palliative care for patients
- Adopt and adapt provincial frameworks and standards for palliative care of people with CKD
- Identify and optimize the care pathway for patients navigating the transplant process, including pre- and post-transplant, in collaboration with Trillium Gift of Life Network
- Ensure the necessary infrastructure is in place across the provincial network for kidney care programs to support pre- and post-transplant care in collaboration with Trillium Gift of Life Network

Improve patients' access to kidney care

- Adapt tools and approaches to improve access to kidney care for First Nations, Inuit and Metis, and rural and remote communities.
- Develop and implement a flexible framework for a community-first approach to kidney care
- Enhance system capacity for optimal and timely vascular and peritoneal access
- Implement models for the delivery of safe, high-quality and accessible care to people with acute kidney injury, CKD and end-stage kidney disease: this includes people requiring specialized care such as those with complex glomerular disease and those with kidney disease during pregnancy

References

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External Environment – Service Utilization – Emergency Department

Provincial and national emergency department trends demonstrate an increase in the aging population with multiple chronic diseases and co-morbidities. As a result of this complexity, the emergency department visit places an increased burden on acute care resources as well as the inter-professional collaborative community care model. Timely access and coordination of the complex patient to community services drives longer length of stays in the emergency and critical care departments.

Discussion

In addition to the ED being frequently used to evaluate and treat patients for acute medical problems and severe injuries, it is also a safety net for patients who lack access to primary health care and community services. Increased ED visits and ICU volumes for persons 45 years of age and over is associated with a greater proportion of illness conditions presenting with an increased use and allocation of more services, medications, and mid-level providers such as occupational therapists, physiotherapists, pharmacists, palliative care specialists, dietician, respiratory therapists, nurse practitioners.

Highlights

I. Higher proportion of aging population;
II. Increased prevalence of chronic diseases (diabetes, COPD, hypertension, rheumatologic), mental health and palliative care cases;
III. Unhealthy living with an increase in obesity, alcoholism, substance abuse, sexual assault presentations

- There is a higher proportion of aging population (65+) and the numbers are steadily increasing. From 2011 to 2031, the baby boom generation will turn 65 and subsequently the proportion of seniors is expected to exacerbate at a higher rate. The population is now living longer and baby boomers are aging. The baby boom will double the number of seniors living in Ontario over the next 20 years. Nearly a quarter of Canadians are likely to be over the age of 65 by 2031.
- In 2010/2011, over 271,000 emergency room visits were made to Ontario hospitals that could have been treated in alternative primary care settings. In addition, patients who are discharged and don't receive adequate home-care are often readmitted. In 2009, there were 140,000 instances of patients re-admitted to the hospital in Ontario within 30 days of their original discharge.
- Rural populations experience higher mortality rates (higher rates of circulatory and respiratory diseases, injury and suicide). Risk factor prevalence is also higher including smoking, obesity and high blood pressure.

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External Environment – Service Utilization – Surgical Program

SAH offers surgical services to residents of the Algoma District with the following services: 6 Operating Suites, Post-Anaesthesia Care Unit, Pre Admission, Inpatient Surgical Unit, Day Surgery, Endoscopy Suite, Ophthalmology OR and Clinic, Minor Procedure Clinic and Urology Clinic.

Discussion

Sault Area Hospital (SAH) will complete approximately 7500 elective surgical cases in the Operating Room in 2017/18. We have introduced non instrumented spine surgery in early 2017. This has allowed us to repatriate this patient population to the Algoma region to receive their care closer to home.
Sault Area Hospital has been designated a level 3 vascular centre; recruitment vascular surgeon will be required in the near future.

Sault Area Hospital is now required to collect vascular services in the CCN Vascular Registry.

Collecting data through the endo DSP file for colonoscopy, Endoscopic Ultrasound (EUS) biopsies and recruitment for a 3rd Gastroenterologist. SAH now collects quality data for endoscopy procedures through the CCO DSP file system. An addition of the Endoscopic Ultrasound has enhanced endoscopy procedures at SAH. CCO will be self-administering set P data for the Operating Room.

Clinic volumes have also seen a significant increase in all areas including Medical Daycare, the large number of patients receiving venofor infusion, with the introduction of a Hematologist to the community. Minor procedures with the addition of an extra wound care clinic monthly to meet increasing demands for vascular outpatient services. A pain Management clinic has been another service provided by Ambulatory Services. The Pre-Admit Clinic will be working on a project drop the pre-op to ensure the most appropriate patents are being seen in the pre-admit clinic. We have also rolled out the utilization of the STOP BANG tool to identify patients at a high risk of Obstructive Sleep Apnea (OSA). Early Recovery After Surgery (ERAS) is being introduced to patients starting with the Pre-Admit appointment Urology and Plastics are currently recruiting for another plastic surgeon which will reallocate of clinic time.
Introduction of the Quality Based Procedure (QBP) funding model will impact how business is conducted. QBPs incorporate evidence-based practices along with the consensus of evidence based cost of the best practice. It will allow SAH the opportunity to standardize care for patients as well as allow patients the ability to receive the best care available closer to home.

Highlights

- Expansion of Telehealth services for pre-operative and post-operative patients that live outside the city.
- Repatriation of the surgical patient population that currently receive treatment out of town.
- Development of centres of excellence within the LHIN.
- Operating Room/ Recovery Room doing ECT 3 days a week.
- We are now running 6 Operating Rooms 1 day a week
- Cancer Surgeries performed at SAH are now under QBP's and CCO
- Continue to incorporate advanced technologies to improve patient surgeries and outcomes
- More focus on the Quality indicators within the program – (i.e. readmissions for total joints, amputations after vascular cases, mcc etc.)

External Environment – Service Utilization – Mental Health & Addictions

All levels of government recognize the interrelation between mental health and addiction as well as the need to integrate these services with other health and social service planning. Trends show an increase in mental illness and substance abuse early and late in life and among females.

Discussion

The terms 'mental illness' and 'addiction' refer to a wide range of disorders that affect mood, thinking and behaviour. Examples include depression, anxiety disorders, schizophrenia, as well as substance use disorders and problem gambling. Mental illness and addictions can be associated with distress and/or impairment of functioning. Symptoms vary from mild to severe. With appropriate treatment and support, most people with mental illness will recover.

Highlights

- In any given year, 1 in 5 Canadians experiences a mental health or addiction problem. Mental illness affects people of all ages, educational and income levels and cultures.
- By the time Canadians reach 40 years of age, 1 in 2 have – **or have had – a mental illness.**
- Almost half (49%) of those who feel they have suffered from depression or anxiety have never gone to see a doctor about this problem. Stigma or discrimination attached to mental illness presents a serious barrier, not only to diagnosis and treatment but to acceptance in the community.
- 4,000 Canadians die by suicide annually – an average of more than 10 suicides per day. Suicide is the second leading cause of death amongst youth and young adults.
- Mental illness is the leading cause of disability in Canada and can be treated effectively.
- In 2014/2015, residents of the NE LHIN had 15,846 visits to Emergency Department (ED) for mental health and substance abuse conditions.
- 15.6% of NE LHIN residents between the age of 0 and 19, who visited the ED in 2014/2015, did so for mental health and substance abuse condition as their main problem.
- Among Ontarians aged 25 to 34, one of every eight deaths is related to opioid use.
- Northeastern Ontario has a higher percentage of drinkers who report heavy drinking (19.9%) compared to Ontario as a whole (16.2%).
- First Nation youth die by suicide about five to six times more often than non-Aboriginal youth.
- The move to legalize marijuana has impacts to the addiction's programs as stated by Additions and Mental Health Ontario
- Legalization presents the opportunity to increase awareness and education, using public health principles, about the known harms and risks of frequent and early cannabis use.
- In Ontario, mental health and addictions services are funded or provided by at least 10 different government ministries. Community care is delivered by 440 children's mental health agencies, 330 community mental health agencies, 150 substance abuse treatment agencies, and about 50 problem gambling centres. No single organization is accountable for ensuring consistent and comprehensive delivery of these services.

Cost

- The economic burden of mental health and addiction issues in Canada is estimated to be about $51 billion per year.
- In Ontario, the annual cost of alcohol-related health care, law enforcement/corrections and lost productivity is estimated to be about $5.3 billion.
- Every $1 spent on mental health and addictions saves $7 in health costs and $30 dollars in lost productivity and social costs.

Strategic priorities: Ontario

- In March 2012, the Minister of Health and Long-Term Care convened an Expert Working Group on Narcotic Addiction to provide advice to the Ontario government on strengthening addiction services and treatment, with a focus on prescription narcotic misuse and addiction.
- In May 2012, the Mental Health Commission of Canada released the mental health strategy – Changing Directions, Changing Lives. In February, 2017, the Ontario government announced a $140 million investment over three years, followed by a sustained increase in funding of $50 million annually. This investment is in addition to the $3.7 billion that Ontario invested in mental health and addictions services in 2015-16.
- The second phase of the Open Minds, Healthy Minds Strategy was unveiled in November 2014 and is built on five foundational pillars:
    1. Promoting health and wellbeing;
    2. Ensuring early identification and intervention;
    3. Expanding housing, employment supports and diversions/transitions from the Justice System;
    4. Providing care at the right time in the right place; and
    5. Funding based on need and quality.
- Mental Health and Addictions Leadership Advisory Council (2014) is a three-year advisory body created by the Government of Ontario. The council will advise the Minister of Health and Long-Term Care on the implementation of Ontario's Comprehensive Mental Health and Addictions Strategy.

Strategic Priorities: Algoma and Sault Ste. Marie

    - The District continues to have ongoing challenges with psychiatric workforce; based on population, there should be 12-14, we currently have 10. Recruitment efforts will continue.
- The number of people in Algoma over age 75 is anticipated to increase by over 50% by 2030. A significant percentage of these individuals will experience age-related mental illness.
- Application for a Level III RWMS is a program priority.

Strategic Priorities: Sault Area Hospital

- To address the high needs patients, as well as the rising risk population, we will implement the guided care nurse modeled after Health Links for the Mental Health and Addiction patient population
- Quality Improvement Plan includes a focus on reducing readmissions to Mental Health and Addictions
- Work continues with community partners to improve access to mental health and addictions services by reducing system fragmentation and duplication of service.
- Implementation of Health Quality of Ontario Standards for major depression as well as schizophrenia
- Building on the work of the newly established Mental Health and Addictions Patient and Family Advisory Council, we aim to improve the experience of patients, families, and care givers when engaging with our services
- Our new Healthcare Information System will be a significant disruptor in our organization and will require effective change management strategies

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External Environment – Service Utilization – Housing (Long-Term Care)

More care is being provided in the home than ever before, representing a significant shift in direction for Ontario health care. Initiatives enable us to care for increasingly higher need patients at home and in the community.

Quick Facts in Sault Ste. Marie for April 2017

- There are 1033 Long-Term Care Home (LTCH) beds
- On average, 24 people moved into a LTCH this month
- 46% of people moved into their first choice on the initial bed offer
- 50 person was placed in a LTCH awaiting their first choice
- There are 605 people waiting for initial LTCH placement
- 655 people are on the LTCH placement waitlist

Average LTCH Availability (as of April 2017)

Note: These figures represent average wait times in each category, based on the total number of people waiting for long-term care in Sault Ste. Marie in the month of April. These wait times will vary depending on accommodation availability, and the gender and placement category of the person waiting for long-term care. Individual patients may select up to 5 LTCHs and would be reflected on more than one waitlist.
For more information on the individual Long Term Care Homes please visit, northeasthealthline.ca

ALGOMA MANOR	
Licensed Beds	95
Number of patients waiting for basic beds	13
Number of days 9 out of 10 people were placed in basic beds	303
Number of patients waiting for semi-private beds	2
Number of days 9 out of 10 people were placed in semi-private beds	321
Number of patients waiting for private beds	3
Number of days 9 out of 10 people were placed in private beds	19
Average number of beds that become available every month	3
Total number of patients waiting	**16**

EXTENDICARE MAPLEVIEW	
Licensed Beds	256
Number of patients waiting for basic beds	441
Number of days 9 out of 10 people were placed in basic beds	N/A
Number of patients waiting for semi-private beds	0
Number of days 9 out of 10 people were placed in semi-private beds	N/A
Number of patients waiting for private beds	3
Number of days 9 out of 10 people were placed in private beds	N/A
Average number of beds that become available every month	7
Total number of patients waiting	**443**

EXTENDICARE VAN DAELE	
Licensed Beds	86
Number of patients waiting for basic beds	184
Number of days 9 out of 10 people were placed in basic beds	406
Number of patients waiting for semi-private beds	1
Number of days 9 out of 10 people were placed in semi-private beds	453

F.J. DAVEY HOME	
Licensed Beds	374
Number of patients waiting for basic beds	395
Number of days 9 out of 10 people were placed in basic beds	498
Number of patients waiting for semi-private beds	5
Number of days 9 out of 10 people were placed in semi-private beds	747

Number of patients waiting for private beds	2
Number of days 9 out of 10 people were placed in private beds	94
Average number of beds that become available every month	2
Total number of patients waiting	**184**

Number of patients waiting for private beds	3
Number of days 9 out of 10 people were placed in private beds	387
Average number of beds that become available every month	10
Total number of patients waiting	**398**

GOLDEN BIRCHES	
Licensed Beds	32
Number of patients waiting for basic beds	29
Number of days 9 out of 10 people were placed in basic beds	1428
Number of patients waiting for semi-private beds	4
Number of days 9 out of 10 people were placed in semi-private beds	746
Number of patients waiting for private beds	4
Number of days 9 out of 10 people were placed in private beds	102
Average number of beds that become available every month	1
Total number of patients waiting	**34**

HORNEPAYNE COMMUNITY HOSPITAL	
Licensed Beds	12
Number of patients waiting for basic beds	5
Number of days 9 out of 10 people were placed in basic beds	N/A
Number of patients waiting for semi-private beds	0
Number of days 9 out of 10 people were placed in semi-private beds	N/A
Number of patients waiting for private beds	0
Number of days 9 out of 10 people were placed in private beds	258
Average number of beds that become available every month	0
Total number of patients waiting	**5**

LADY DUNN HEALTH CENTRE	
Licensed Beds	16
Number of patients waiting for basic beds	15
Number of days 9 out of 10 people were placed in basic beds	748
Number of patients waiting for semi-private beds	0
Number of days 9 out of 10 people were placed in semi-private beds	N/A
Number of patients waiting for private beds	0
Number of days 9 out of 10 people were placed in private beds	N/A
Average number of beds that become available every month	1
Total number of patients waiting	**15**

MAUNO KAIHLA KOTI	
Licensed Beds	60
Number of patients waiting for basic beds	285
Number of days 9 out of 10 people were placed in basic beds	N/A
Number of patients waiting for semi-private beds	8
Number of days 9 out of 10 people were placed in semi-private beds	886
Number of patients waiting for private beds	10
Number of days 9 out of 10 people were placed in private beds	N/A
Average number of beds that become available every month	1
Total number of patients waiting	**292**

ST. JOSEPH'S MANOR

Licensed Beds	64
Number of patients waiting for basic beds	19
Number of days 9 out of 10 people were placed in basic beds	901
Number of patients waiting for semi-private beds	0
Number of days 9 out of 10 people were placed in semi-private beds	20
Number of patients waiting for private beds	0
Number of days 9 out of 10 people were placed in private beds	789
Average number of beds that become available every month	2
Total number of patients waiting	**19**

References:

Long Term Care Home Wait Times for Sault Ste. Marie - CCAC

External Environment – Service Utilization – Home Care

More care is being provided in the home than ever before, representing a significant shift in direction for Ontario health care. Initiatives enable us to care for increasingly higher need patients at home and in the community.

Highlights

- In Ontario, 14 Community Care Access Centres (CCACs) – funded by Local Health Integration Networks (LHIN) through the Ministry of Health and Long-Term Care (MOHLTC) – facilitate home care to patients, health care services to children in schools, access to long-term care homes, and palliative care at home.
- In 2013/2014, CCAC services were provided to over 650,000 clients including seniors, medically fragile children, and people living with chronic conditions, transitioning home from hospitals, and seeking palliative care wishing to die at home.

Funding

- In the 2015 Ontario Budget, the commitment to increase funding for home and community care was extended. Funding will be increased by 5% each year, investing another $750 million across the province over the next three years.

Strategies and initiatives

- Launched in May 2015, Patients First: A Roadmap to Strengthen Home and Community Care is the first phase of the Ministry of Health & Long-Term Care's (MoHLTC) plan to remake the home and community care sector. This Roadmap was informed by the work of the MoHLTC's expert group on home and community care, and its report Bringing Care Home.
- The Roadmap includes 10 steps to strengthen home and community care:
    1. Develop a statement of home and community care values;
    2. Create a levels of care framework;
    3. Increase funding for home and community care;
    4. Move forward with bundled care;
    5. Offer self-directed care;
    6. Expand caregiver supports;
    7. Enhance support for personal support workers;
    8. More nursing services;
    9. Provide greater choice for palliative and end-of-life care; and
    10. Develop a capacity plan.

References

North East Community Care Access Centre Annual Report 2015

Ministry of Health & Long-Term Care (2015). Patients First: A roadmap to strengthen home and community care. May 2015.

External Environment – Service Utilization – Maternal Child Program

Maternal Child program has been renamed Women and Children's Health program to better align with the patient population we serve in that area

BORN (Better Outcomes Registry & Network) Ontario is a provincial initiative to ensure the best possible beginnings for life long health.

BORN Ontario indicates that many factors influence the demands on both general and highly specialized obstetrical and neonatal services in the region. These factors also affect the care provided to Pediatric patients. These include the background characteristics and health of the obstetrical population (such as maternal age and underlying medical co-morbidities), risk factors (such as multifetal gestation and previous caesarean), obstetrical practices with regard to the use of intrapartum interventions (such as labour induction and primary or repeat caesarean delivery), and prevalence of averse newborn outcomes (such as preterm birth, growth restriction, and birth depression).

It must also be acknowledged that the unique geography, transfer patterns and health service issues in Northern Ontario provides additional challenges that can affect outcomes.

Sault Area Hospital, infants born from May 1, 2016 – May 23, 2017

Summary of denominator totals

Sault Area Hospital, infants born from 01-May-2016 to 23-May-2017

Number of women who gave birth	880	
Number of infants	887	
Number of live births	885	
Number of stillbirths	2	
Singletons	863	
Sets of twins	11	(22 infants)
Sets of triplets	1	(2 infants)
Unknown if singleton or multiple birth	0	

Multiple gestation

Sault Area Hospital, infants born from 01-May-2016 to 23-May-2017

Type of gestation	# Live births	% Live births	% Valid
Singleton	861	97.3	97.3
Twins	22	2.5	2.5
Triplets	2	0.2	0.2
Total live births	**885**		

Neonatal health conditions

Sault Area Hospital, infants born from 01-May-2016 to 23-May-2017

Neonatal health conditions	# Live births	% Live births	% Valid
None	730	82.5	84.2
Hyperbilirubinemia	53	6.0	6.1
Hypoglycemia	56	6.3	6.5
NAS - Neonatal Abstinence Syndrome	12	1.4	1.4
Other	30	3.4	3.5
Missing data	18	2.0	-
Total infants with one or more neonatal health conditions	**137**	**17.5**	**15.5**
Total live births	**885**		

Transfers to NICU

Sault Area Hospital, infants born from 01-May-2016 to 23-May-2017

Transfers to NICU/SCN	# Live births	% Live births	% Valid
NICU/SCN in same hospital	108	12.2	12.2
Total number of infants transferred	**108**	**12.2**	**12.2**
Total live births	**885**		

Final neonatal disposition

Sault Area Hospital, infants born from 01-May-2016 to 23-May-2017

Final neonatal disposition	# Live births	% Live births	% Valid
Home	787	88.9	89.3
Transfer to NICU/SCN, same hospital	92	10.4	10.4
Child and Family Services Apprehension	1	0.1	0.1
Neonatal Death	1	0.1	0.1
Missing data	4	0.5	-
Total live births	**885**		

References

Data source - BORN Ontario, 2016-2018

External Environment – Service Utilization – Laboratory Services

Discussion

The laboratory at Sault Area Hospital is licensed by the Ministry of Health and Long Term Care to support patient care through diagnostic and therapeutic services including the following:

- Biochemistry
- Pathology
- Cytology
- Hematology
- Microbiology
- Transfusion Medicine
- Forensic Pathology Unit

Highlights

- SAH Laboratory performs over 2.5 million procedures annually
- "An estimated 60 to 70 percent of all decisions regarding a patient's diagnosis, treatment, hospital admission and discharge are based on laboratory test results" (Mayo Clinic)
- SAH operates one of only six Regional Forensic Pathology Units (RFPU) in Ontario. This centre of excellence for forensic pathology is intended to improve forensic pathology capacity to service remote northern and First Nations communities.

Strategic Priorities: Ontario

- The ministry established the Laboratory Services Expert Panel to recommend a future funding model for community labs with a focus on value, quality, and access. On November 12, 2015, The Laboratory Services Expert Panel Review released a report with important recommendations to improve and modernize laboratory funding and services.
- Institute for Quality Management in Healthcare (IQMH) conducts a mandatory Ontario Laboratory Accreditation program to ensure the appropriate standards for laboratory testing are met in the province.
- The Ministry of Health and Long-Term Care established the Quality Management Partnership (QMP) in March 2013. They work closely with physicians, patients/service users and other healthcare providers and organizations to implement, over the next three to four years, provincial quality management programs for three selected health service areas: colonoscopy, mammography and pathology.
- Work continues by the CMLTO (College of Medical Laboratory Technologists of Ontario) to regulate medical laboratory assistants and medical laboratory technicians.

Strategic Priorities: SAH

- The new Healthcare Information System project will be a major undertaking for the laboratory, as the system build is one of the largest in the project. Substantial dedicated time and resources will be required.
- Institute for Quality Management in Healthcare (IQMH) comprehensive accreditation assessment visit is due and will be conducted in fall of 2017
- Quality Management Partnership (QMP) requirements continue to be implemented, and will continue over the next 2 years
- Recruitment of Pathologists will be a key focus for the laboratory as we look to provide a regional service to Algoma and the NELHIN
- Capital needs of this highly automated program continue, with major capital investments continuing throughout the next 1-5 years

- eHealth Ontario strategies must be prioritized with the new HIS work to ensure alignment with provincial reporting requirements

References

http://www.health.gov.on.ca/en/common/ministry/publications/reports/lab_services/

http://www.mayo.edu/mayo-clinic-school-of-health-sciences/careers/laboratory-sciences

External Environment – Service Utilization – Food Services

Malnutrition

- Malnutrition in hospital environments continues to be a focus of quality improvement for Clinical Nutrition.
    - working on defining the types of therapeutic diets (and what each diet is comprised of – what is included and excluded, etc.) and then providing therapeutic diets for patients based on patients' individual health requirements.
    - Focus on malnutrition issues specifically in areas of coding, assessments and intervention strategies;
    - Follow best practice in place in other jurisdiction or create a best practice.

Meal delivery systems (Steamplicity):

- Market leading concept, new innovative food preparation and delivery model;
- Concept is used in multiportion, single-plated option for health care or single portion vending option;
- Reduction in space and capital cost requirement;
- Broader menu choice; and
- In future, food services may have a more active role in the Accreditation process or requirements.

External Environment – Service Utilization – Pharmacy

Increased Regulatory Oversight:

- The Ontario College of Pharmacists has fully implemented their Hospital Pharmacy Accreditation process. SAH had a positive initial visit in august 2015 and is scheduled for a 2nd inspection in August 2017 to assess our progress to achieve compliance with the 416 specific standards.
- National Association of Pharmacy Regulatory Authorities (NAPRA) has recently released new standards governing non-sterile, sterile, and hazardous compounding and full compliance is expected by January 2019.
- SAH can expect ongoing regulatory scrutiny of pharmacy operations and smaller sites in our region will look to SAH as a hub hospital to assist with compliance with the increased oversight.

Transforming Healthcare:

With increasing financial pressures facing Ontario hospitals, pharmacy must support the provision of high quality, cost-effective care. Specifically, we will:

- Formulary Management through Pharmacy and Therapeutics Committee and daily recommendations for formulary alternatives.
- Standardizing care will ensure all our patients are receiving reliably high quality care to achieve the best possible outcomes. Pharmacy will be involved in ensuring Quality Based Procedures best practices are integrated into our pharmacists' standard clinical work, engineered into order sets/documentation, and programmed into the new Meditech.
- Linking care provided in hospital with our community partners through the improvement of our medication reconciliation on admission, transfer, and discharge is integral to ensure we are providing safe care during the patient's stay and set them up for success as they transition back to community.
- Supporting our ambulatory clinics (ADCP, Renal, 2A Follow-up Care Clinic, and Ambulatory Care) with our iCcare Pharmacy will improve the patient experience for these areas and strengthen the retail pharmacy operation.

Medication Safety:

With the increased regulatory oversight for hospitals' medication processes, a greater emphasis is placed on having a medication safety strategic plan that has hospital wide accountability.

Technology:

- SAH is lagging in its adoption of technology to improve the safety of the medication management process.
- With the pursuit of advanced clinicals through the Meditech 6.1 project, SAH will adopt many solutions to improve medication safety such as: Electronic Medication Administration Record (eMAR) with Barcode Medication Verification (BMV), Computerized Physician Order Entry (CPOE), and Electronic medication Reconciliation (eMed Rec)
- The implementation of IV SMART pumps would add a layer of safety to the administration of IV therapies which have a higher risk of harm to patients when errors do occur.

Education:

- Both initial and ongoing, to staff and physicians on the technology implemented will reduce unsafe "work arounds" and reinforce best safety practices.
- Standardized care requires ongoing education and competence assessment.

Drug Therapy Trends:

- Oral chemotherapy currently comprises 40% of ADCP treatments and will continue to grow. This presents a challenge of safely managing these high risk medications in partnership with community pharmacies or by building internal outpatient dispensary for oral chemotherapy.
- Genetically targeted therapies will continue to grow in number and will be introduced at a premium cost. So although oral therapies will grow in number, the remaining systemic treatments will be introduced at a premium cost. Biosimilar “generic” medications are trending in the US currently, but the legislation is less clear in Canada at this time so costs will continue to rise for these products.
- Drug shortages will continue into the foreseeable future and beyond. As hospitals seek to drive drug costs down, sole award contracts lead to fewer manufacturers of generic medications leaving the marketplace vulnerable to shortages.

External Environment – Service Utilization – Allied Health

Physiotherapy

Physiotherapists are members of the College of Physiotherapists of Ontario. Physiotherapists manage and prevent many physical problems caused by trauma, illness, disease, sport and work related injury, aging and long periods of inactivity.

The Physiotherapist has a number of roles in the process of rehabilitation which include:

- performing neuromuscular assessments related to patient function and potential for recovery
- performing initial assessments regarding range of motion, strength, mobility aids, assistance required and patient safety during ambulation, stairs and functional skills
- provide gait and balance training
- prescribe and utilize electrotherapeutic modalities as required
- assign patients to physiotherapy assistant as required
- provide hands on manual therapy
- provide physiotherapy outpatient services in both hand and general outpatients for clients with a variety of diagnoses including post-surgical, post-fractures, amputees, post-stroke etc.
- provide physiotherapy inpatient services working with interdisciplinary healthcare team members to provide patient centered care on medical, surgical, intensive care, paediatric, oncology, palliative, rehabilitation and long term care units

Outpatient physiotherapy services are provided to clients with referrals from:

- orthopaedic surgeons
- patients discharged from hospital with neurological problems, CVA (Cerebrovascular accident), tumors, etc.
- amputee clinic for pre and post prosthetic training
- plastic surgeons for post hand surgery therapy

Outpatient Occupational Therapy - Neuro Service

Occupational Therapists (OTs) are members of the College of Occupational Therapists of Ontario. Occupational Therapy is concerned with promoting health and well-being through everything that people do during the course of everyday life. Some Occupational Therapists work with inpatients, while others work with individuals on an outpatient basis.

OTs are key members of the interdisciplinary care team, assisting patients with cognitive perceptual problems and functional impairments, after experiencing a stroke, joint replacement, or other medical diagnosis.

The Occupational Therapist has a number of roles in the process of rehabilitation which include:

- Cognitive assessment & treatment
- Perceptual assessment & treatment
- Upper extremity assessment & treatment
- Activities of Daily Living (ADL) assessment & treatment
- Instrumental Activities of Daily Living (IADL) assessment & treatment
- Consultation with other services (i.e. Social Work, Physiotherapy) is conducted, when necessary.
- Assist individuals with disabilities to be able to do the things they need to do or want to do
- Advocate for patients and help them meet their goals
- Opportunity to work across the hospital.

Outpatient physiotherapy services include:

- Following an acquired brain injury (i.e. CVA, brain tumor, etc.), individuals may have difficulties which interfere with their functional abilities and which impact on their participation in roles and meaningful activities.
- In the Outpatient Neuro service, the Occupational Therapist provides assessment, treatment, education, and consultation to clients requiring additional intervention for specific rehabilitation goals in the areas of self-care (i.e. bathing, dressing), productivity (work, housework) and leisure (sports, hobbies).
- Together with the client, an individualized treatment plan is developed targeting client identified goals towards a desired outcome.

The overall goals of this service are to facilitate community reintegration and optimize functional independence in the client's activities of daily living.

Respiratory Therapy

The Respiratory Therapy Department provides 24 hours service to patients with respiratory illness. This includes mechanically ventilated patients in Critical Care, Neonatal Intensive Care and Emergency.

- "Early and effective rehabilitation" is a philosophy of care that can and should occur at all points along the care continuum including acute care, long-term care and community based care.
- When effectively provided by an engaged interprofessional team that includes family members, a rehabilitation focus will improve an individual's independence and function and can reduce ALC days, hospitalizations and demand for LTC beds.
- It should be supported by a system that endorses long-term follow-up and successful community re-engagement.

Speech, Language, and Swallowing (Speech Pathology)

A speech- language pathologist may work alone or as part of a team to help individuals of all ages to communicate effectively and to eat and swallow safely.

A Speech Pathologist can:

- identify, assess, evaluate, treat, manage, educate and help prevent language, speech, voice, fluency, cognitive, and other communication disorders
- identify, assess, evaluate, treat, manage, educate and prevent swallowing problems

The Speech Language pathology Department services all inpatients and adult outpatients for the Algoma District with acute medical or surgical pathologies.

These include:

- swallowing - bedside screening assessments, videofluroscopy assessments, and swallowing treatment
- Neurogenic speech and language disorders - assessment and treatment of right and left hemisphere brain injury (stroke, aneurysm, degenerative diseases etc.)
- oral, velo-pharyngeal and laryngeal surgery - pre and post- surgical counseling, rehabilitation, purchasing adaptive equipment
- non-vocal, tracheostomized and ventilator dependent patients - augmentive and alternative communication, speaking valves, purchasing adaptive equipment
- inpatient premature and medically involved peadiatric patients - feeding and swallowing assessment and treatment

Registered Dietitians

Registered Dietitians are qualified health professionals. By law, only individuals who are registered with the College can practice in the province, using the title "Registered Dietitian" or the abbreviation "RD". Registered dietitians in Ontario must adhere to regulations set by the College of Dietitians.

Registered Dieticians:

- Advocate for your nutritional needs and utilize appropriate nutritional care in a respectful manner working towards positive outcomes in your overall health.
- Apply medical nutritional therapy to prevent and treat disease states;
- Improve patients' overall health with nutrition therapy;
- Educate patients, their family members and their caregivers about the importance of sound nutrition in disease management and healing;
- Conduct research, focusing on evidence-based practice and incorporating best practice into therapy;
- Provide education to dietetic interns who are training towards becoming registered dietitians.

At Sault Area Hospital, registered dietitians' responsibilities include:

- Identifying nutritional problems, assess, treat and plan nutritional care of patients (together with the health care team) monitor and improve the effectiveness of nutrition intervention in the promotion of healing and overall patient health;
- Acting as a resourceful member of the healthcare team.

Registered dietitians provide nutrition services to the following patient areas:

- Surgery
- Medicine
- Psychiatry
- Renal
- Intensive Care
- Oncology
- Maternal and Child
- Rehabilitation
- ALC and TCU

Malnutrition in hospital environments continues to be a focus of quality improvement for Clinical Nutrition.

- Focus on malnutrition issues specifically in areas of coding, assessments and intervention strategies;
- Follow best practice in place in other jurisdiction or create a best practice.

North East Rehabilitation Network

Opportunities at SAH to be further explored and developed include:

- Successful community re-integration for patients - An easy to follow plan with minimal or no gaps in services when discharged from hospital, preferably with the guidance of a system navigator.
- Enhanced community based services involving health care teams with a mandate of:
    1. Chronic disease monitoring and education to prevent hospital visits, admission and decrease LOS; and
    2. Illness and injury prevention.
- Implementation of evidence based best practices and outcomes measures, e.g. Stroke Best Practice.

- Continued efforts to incorporate the philosophy of the importance of the strength of the entire care team in addressing the "rehab" needs of our patients during the continuum of their stay with us and after into our plans for that care.
- Geriatric services: this covers the range of community partners, prevention, senior friendly initiative, discharge planning and follow-up in the community.
- OP, outreach and OTN expansion
- Increased integration and transfer of data into EMR (paperless PFT reporting, ventilator data direct to EMR)
- Increased use of POC testing (ABG etc. for more timely results for decision making)
- Increased effort on chronic disease management and ensuring proper follow-up care and monitoring.

References

North East Rehabilitation Network website

External Environment – Service Utilization – Stroke Program and Medical Follow-Up Clinic

Stroke Program

- Sault Area Hospital is a proud partner in the Ontario Stroke Network.
- As a designated District Stroke Center we are committed to providing excellence in stroke care for our entire District, from Blind River to Horne Payne.
- Our state of the art diagnostic equipment and telemedicine ability makes it possible to diagnose and treat stroke quickly.
- With a dedicated physicians, nurses, allied health providers and partners in the community we aim to provide the best possible care to stroke patients.

Medical Follow-up Clinic

The Medical Follow-up Clinic to provide patients with timely access to care within 24–72 hours after discharge from the Emergency Department or an inpatient unit

- Patients with the diagnosis of Acute Coronary Syndrome, Chronic Obstructive Pulmonary Disease, Pneumonia, and Cellulitis, in addition to patients with Congestive Heart Failure are referred to this clinic.
- The clinic operates using an inter-disciplinary team model comprising of a Nurse Practitioner, Internist, Registered Nurses and a Pharmacist. The clinic shares space with the Pacemaker Clinic, Algoma Geriatric Clinic, Seniors Mental Health and Behavioural Supports Ontario.
- Service of the clinic allows timely access to a care team on an outpatient basis.
- Emergency Department patients or those on inpatient units who require follow-up treatments such as intravenous antibiotics or internal medicine assessments, can now receive this care in a rapid, outpatient setting.
- Provides faster access to patient-centred care, all while preventing unnecessary admissions to hospital and decreasing length of stay.

External Environment – Service Utilization – Diagnostic Imaging

Interventional Radiology

- As technology enhances, the demand on these services will increase globally. The effectiveness of the procedures will decrease pressures on OR services. The same outcomes will be able to be achieved without the use of General Anesthetics and complex OR teams.

MRI

- Rapidly changing technology once again will change how imaging is provided in this area. Changes to imaging algorithms will enable scans to be performed in less time and with enhanced detail. Wait times will be positively impacted.

CT

- At a local level, the 64 slice CT scanner will be replaced in the next 3 years. This will allow SAH to meet the growth in this area, namely, slice parameters. Movement to a 128 or 256 slice scanner will enable faster throughput, different scanning techniques and faster diagnosis and treatment
- In all of the above noted areas, there will be a large emphasis on limiting Ionizing radiation delivered to patients. This comes about as a result of patients being well-informed on the effects of such.
- New modalities such as PET scanning (Positron Emission Tomography) will continue to grow and perhaps find a place in the Northeast region.
- From a staffing perspective, cross training in select areas is where the industry and the department are headed. This allows for more efficient use of staffing.

References

www.ehealthontario.on.ca/en/initiatives/view/olis

http://www.cshp.ca/programs/cshp2015/

External Environment – Service Utilization – Infection Prevention and Control

Infections and antibiotic resistant organisms (AROs) result in significant morbidity, mortality and economic costs to the health care system. Robust Infection Prevention and Control (IPAC) programs are a priority in all health care settings as hospital acquired infections (HAIs) are on the rise globally.

Discussion

The Provincial Infectious Disease Advisory Committees were first established in 2004 to respond to the recommendations by the Expert Panel on SARS and Infectious Disease Control to provide a standing source of expert advice on infectious diseases in Ontario. Since their creation, PIDAC committees have contributed to a wealth of knowledge that is embodied in a library of best practice documents, reports and recommendations on matters related to communicable diseases, immunization, infection prevention and control and surveillance.

SAH follows the Best Practice Guidelines developed by The Provincial Infectious Disease Advisory Committee on Infection Prevention and Control (PIDAC-IPC). PIDAC is a multidisciplinary scientific advisory body that provides evidence-based advice regarding multiple aspects of infectious disease identification, prevention and control. The work is guided by best available evidence and updated as required. These Best Practice documents and tools reflect consensus positions on what PIDAC deems sensible practice. *(Excerpts from PIDAC-IPC Best Practices for Infection Prevention and Control Programs in Ontario; In all Health Care Settings, 3rd edition)*

Highlights

- A survey of Canadian hospitals with more than 80 beds reported in 2008 that hospitals carried out, on average, only two-thirds (68%) of the recommended surveillance activities based on Study on the Efficacy of Nosocomial Infection Control (SENIC) project findings and only 64% of the recommended infection control activities.
- Mandatory standards, monitoring and public reporting are necessary to understand and tackle HAIs.
- About 8% of children and 10% of adults in Canadian hospitals have an HAI at any given time.
- It has been estimated that 220,000 incidents of HAI occur each year, resulting in more than 8,000 deaths in Canada.
- It is estimated that AROs increase the annual direct and indirect costs to patient by an additional $129 million in Canada.
- Most HAIs are preventable. As many as 70% of some types of HAIs could reasonably be prevented if infection prevention and control strategies are followed.
- More than 50% of HAIs are caused by bacteria that are resistant to at least one type of antibiotic.
- Mortality rates attributable to *Clostridium difficile* infection have more than tripled in Canada since 1997.
- The healthcare-associated methicillin-resistant *Staphylococcus aureus* infection rate increased more than 1,000% from 1995 to 2009.
- About 80% of common infections are spread by healthcare workers, patients and visitors.
- Proper hand hygiene can significantly reduce the spread of infection.
- Best practices in preventing infection can reduce the risk of some infections to close to zero

Surveillance for Hospital Acquired Infections

Nearly all hospitals in Canada routinely monitor the incidence of HAIs through surveillance activities. Surveillance is either broad (assessing all care areas) or targeted to specific units (e.g. the intensive care unit) or for specific infections that are a priority for a particular hospital.

- ACCREDITATION - Patient safety is a priority for accreditation, which is implemented and monitored as part of Required Organizational Practices (ROPs) developed by Accreditation Canada. Public reporting of hospital infections and hand hygiene compliance was initiated in Ontario in 2008 as a means of improving quality of care while ensuring both transparency and accountability.
- HAIs complicate the lives of Canadians when they are at their most vulnerable, resulting in longer illnesses and greater risk of death. The longer patients remain infectious, the longer they can spread infectious agents to others.
- Infection Prevention and Control Programs (IPAC) have been shown to be both clinically effective and cost-effective, providing important cost savings in terms of fewer HAIs reduced length of hospital stay, less antimicrobial resistance and decreased costs of treatment for infections.
- You can successfully prevent and control infection with these five evidence-based infection control strategies:
    - Establish an aggressive hand hygiene program
    - Clean and decontaminate the environment and equipment
    - Implement contact precautions for any patient infected or colonized with a superbug
    - Perform methicillin-resistant *Staphylococcus aureus* and vancomycin-resistant *Enterococcus* screening surveillance on admission and at other times
    - Regularly report superbug infection rates to frontline and hospital leaders
- There is conclusive evidence to show that the establishment of a surveillance system for HAIs is associated with reduction in infection rates.
- Surveillance involves planning (types of infections to be surveyed), data collection (using validated, published definitions), data analysis (calculating incidence density rates during a defined period of risk), interpretation of data (improve practices based on data to lower HAIs), communication of results (targeted to those with the ability to change practice), and evaluation (periodic review of surveillance system).
- At SAH, IPAC conducts surveillance for AROs including Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Enterococci (VRE), *Clostridium difficile* (CDI), and Carbapenemase Producing Enterobacteriaceae (CPE).

Hand Hygiene (HH)

- Proper hand hygiene—washing hands with soap and water or using alcohol-based hand rubs—is the single best way of preventing HAIs.
- Even small improvements in hand hygiene result in large benefits: an increase in adherence to hand hygiene by only 20% has been shown to reduce the rate of HAIs by 40%.
- HH audits have been conducted at SAH since 2008/2009, with ~5,000 per year now being done. Annual results are posted on the SAH and Health Quality Ontario (HQO) websites. There are four moments of hand hygiene for auditing:
    1. before initial patient/patient environment contact
    2. before aseptic procedures
    3. after body fluid exposure risk
    4. after patient/patient environment contact
- For the 2016/17 fiscal year, SAH's HH compliance rate for Moment 1 was 74.8% and Moment 4 was 89.1% compared to a provincial average of 87.32% for Moment 1 and 91.23% for Moment 4 (as of March 2016).

Clostridium Difficile (CDI)

This organism causes problems when it sets up shop in the colon; it can produce a toxin that damages the lining of the intestines, resulting in symptoms that range from mild diarrhea all the way to death. Fortunately, not all strains produce toxin, and not all strains that can make toxin actually do so. In general, people become sick with C. difficile when they become colonized with a toxin-producing strain that actually starts to produce toxin – usually because the patient has received antibiotics that kill off other naturally occurring bacteria in the intestines and allow the C. difficile to thrive.

- The SAH CDI rate for the 2016-17 fiscal year was 0.24 (target 0.18) with the provincial average being 0.22 as of August 2016.

MRSA and VRE

While MRSA has traditionally been thought of as an organism that one picks up in the health care setting, new strains have arisen in the community over the past decade. In fact, upwards of 18% of all patients going to emergency departments in some parts of the country with nasty skin infections have community-associated MRSA. Simply becoming colonized with MRSA prolongs a patient's length of stay – partially because of the control measures required to keep other patients from being infected, which can hamper their care and discharge plans.

The good news about VRE is that, like all Enterococci, these organisms are not nearly as virulent (nasty) as many of the other superbugs we deal with. VRE tends to focus on places like the urinary tract, heart valves, and the blood, and also on any prosthetic devices they can get their little bacterial hands on, such as artificial joints, prosthetic heart valves and intravenous catheters. VRE infections require prolonged (often months-long) treatment with antibiotics, and the treatments frequently fail.

HAIs:

- SAH's MRSA rate for 2016-17 was 0.54 and the VRE bacteremia rate for the same period was 0.24.

Community Acquired:

- For the fiscal year 2016-17 SAH had a total of 96 cases of Community Acquired MRSA and 16 cases of Community Acquired VRE.

Ventilator Associated Pneumonia (VAP) and Central Line Infection (CLI)

- VAP is defined as pneumonia (a serious lung infection) that can occur in patients (specifically ICU patients) who need assistance breathing with a mechanical ventilator for at least 48 hours.
    - SAH's VAP rate for Q4 2016/17 was 2.45 (1 case).
- CLI occurs when a central venous catheter (or "line") placed into a patient's vein gets infected. This happens when bacteria grow in the line and spreads to the patient's blood stream.
    - The CLI rate for Q4 2016/17 was 2.12 (1 case).

Strategies

Antimicrobial Stewardship Program (ASP)

- The SAH-ASP program has been established since 2013 and is a multidisciplinary and collaborative program. The team has grown and consists of physicians, pharmacists with ASP training , Infection control practitioners, pharmacy manager, nurse managers, nurse educator, and a microbiology laboratory senior technologist
- The ASP Committee is responsible for advancing professional practices as it relates to the optimal selection, dosage, and duration of the antimicrobial treatment that results in the best clinical outcome for the treatment or prevention of infection with minimal toxicity to the patient and minimal impact on subsequent resistance
- Our team is committed to working on our intra-team communication and strengthening our team through internal development and team building; Physician and nursing engagement and participation is an ongoing goal of the program;
- The SAH-ASP program has been reporting data for ICU PA&F rounds. The goal is to have readily accessible data to help drive, measure and monitor antimicrobial use and initiatives across the organization.
- The SAH-UHN committee has a responsibility and desire to improve antimicrobial use within the organization by educating ourselves and our community partners. Planned development in knowledge, expertise and other skills critical to Antimicrobial stewardship principles will build capacity within the organization.

Hand hygiene program

- Reduction of Hospital Acquired infections (HAI) leads to an improved patient experience and overall population health for our patients. Hand hygiene is one of the most significant influencers in the reduction of HAI.
- The importance of excellent hand hygiene practices has led to an evaluation of the audit process by the IPAC team.

- Hand hygiene continues to be an improvement initiative on the 17/18 Quality Improvement Plan (QIP).
- Our goal continues to be to achieve a 100% compliance rate across Moments 1 and 4.
- Increased monitoring capacity

    - We have increased the number of audits being conducted by 30% during 2016/2017 as part of the QIP initiative.
    - We recruited additional volunteer auditors and new patient care management staff to support this goal.
    - IPAC has rolled out multiple visual tools on inpatient units and are making a concerted effort to increase these initiatives in 2017/18.

References

Association for Professionals in Infection Control and Epidemiology. (2009). APIC text of Infection Control and Epidemiology, 3rd Ed.

Health Quality of Ontario website

IPAC Canada

CPSI-ISCP Canadian Patient Safety Institute

PHAC Public Health Agency of Canada - Ontario Agency for Health Protection and Promotion, Provincial Infectious Diseases Advisory Committee. Routine Practices and Additional Precautions in All Health Care Settings. 3rd edition. Toronto, ON: Queen's Printer for Ontario; November 2012.

Public Health Ontario "Just Clean Your Hands" 2008-2011

External Environment – Peer and Referral Hospitals – Strategic Priorities

Hospitals are leveraging technology to ensure access to and sharing of information including social media, and bringing health care and services to their patients.

Hospitals are moving services to the community and focusing on mental health and chronic conditions.

Discussion

SAH's referral hospitals and other nearby hospitals in the NE LHIN are increasing their focus on integrated, community care and expanding services for patients with mental health concerns and chronic conditions.

Hub Hospitals within the North East LHIN

The North East LHIN funds 25 hospitals. The first Hospital Service Accountability Agreements or HSAAs were signed in 2008 and covered fiscal years 2008-2010. Subsequent to the initial period HSAAs were amended for four additional one-year periods. The latest amendment is for a period of 6 months, from October 1, 2014 to March 31, 2015. All hospitals listed below have amended agreements dated April 2016.

- Anson General Hospital (Iroquois Falls)
- Bingham Memorial Hospital (Matheson)
- Blind River District Health Centre
- Englehart and District Hospital
- Espanola General Hospital
- Health Sciences North/Horizon Santé-Nord (Sudbury)
- Hôpital Notre Dame Hospital (Hearst)
- Hornepayne Community Hospital
- Kirkland and District Hospital
- Lady Dunn Health Centre (Wawa)
- Lady Minto Hospital (Cochrane)
- Manitoulin Health Centre
- Mattawa General Hospital
- North Bay Regional Health Centre
- Sault Area Hospital
- Sensenbrenner Hospital (Kapuskasing)
- Services de santé de Chapleau Health Services
- Smooth Rock Falls Hospital
- St. Joseph's Continuing Care Centre of Sudbury
- St. Joseph's General Hospital Elliot Lake
- Temiskaming Hospital (Temiskaming Shores)
- Timmins and District Hospital
- Weeneebayko Area Health Authority (Moose Factory)

Referral Hospitals

- North Shore Health Network (3 sites - Blind River, Thessalon, Richards Landing)
- Lady Dunn Health Centre (Wawa)
- Espanola Regional Hospital and Health Centre (Espanola)
- St. Joseph's General Hospital (Elliot Lake)

If another service is in overcapacity (example: Mental Health) or it is urgent then SAH can get "critical requests" and referrals from any hospital in the NE LHIN.

Highlights

Health Sciences North

- In June 2013, Health Sciences North (HSN) in Sudbury launched its Strategic Plan for the period 2013 to 2018. The Plan focuses on providing quality, safe, evidence-based care, innovation and leading the development of a 'hospital without walls'. This Plan also introduced a new Mission, Vision and Values Statement:
    - Mission – Improve the health of northerners by working with our partners to advance quality care, education, research and health promotion;
    - Vision – Globally recognized for patient-centred innovation;
    - Values – Excellence, Respect, Accountability, Engagement.
- The Strategic Priorities of HSN are:
    - Excellence in evidence-based care
    - Innovators
    - Leaders in Care Transition
- As part of its new Strategic Plan, HSN also created a new Paediatric Centre of Excellence in its Sudbury Memorial Hospital site called the North Eastern Ontario Health Centre for Kids (NEO Kids), now relocated to the Ramsey Lake Health Centre site in July 2015. NEO Kids provides specialty paediatric outpatient care to children aged 0 to 18 years of age close to home. Phase 1 included the relocation of the Pediatrician offices and Nurse Practitioner clinics to HSN's main site. Phase 2 planning includes building an expanded NEO Kids facility beside the Children's Treatment Centre at the back of the hospital. This Centre will feature a medical day care, pharmacy, diagnostics and lab services and a Child Advocacy Centre.

London Health Sciences Centre

- The London Health Sciences Centre (LHSC) is now using point-of-care ultrasound in most areas of the hospital to guide procedures such as central line placements and drainage of fluid around the lungs.

Blind River District Health Centre[1]

- In January 2014, Blind River District Health Centre launched its 2014-2017 Strategic Plan. The Plan is built on 3 enablers – financial sustainability, sustainable human resources and enhanced stakeholder communication – and 3 pillars – quality improvement and patient safety, healthy rural communities, and integrated rural health model. To achieve its strategic direction, BRDHC focus on preventative health care strategies, increasing culturally sensitive access to care, leveraging technology, explore new partnerships, and improve communication processes and channels.

References

Blind River District Health Centre (2014). 2014-2017 Strategic Plan

Health Sciences North (2013). 2013-2018 Strategic Plan

Health Sciences North (2013). HSN Launches Strategic Plan 2013 – 2018. Dialogue – Staff Newsletter. June

North Eastern Ontario Health Centre for Kids (NEO Kids)

London Health Sciences Centre (2014). London Health Sciences Centre leading the way in ultrasound technology. October 22

Mulligan, C. (2013). Hospital eyes pediatric centre. Sudbury Star. February 22

Table of Images

1 SAH By the Numbers

2 SAH Strategic Plan on a Page

Sault Area Hospital
Hôpital de Sault-Sainte-Marie

Strategic Plan 2016 - 2021

Exceptional people working together to provide outstanding care in Algoma.

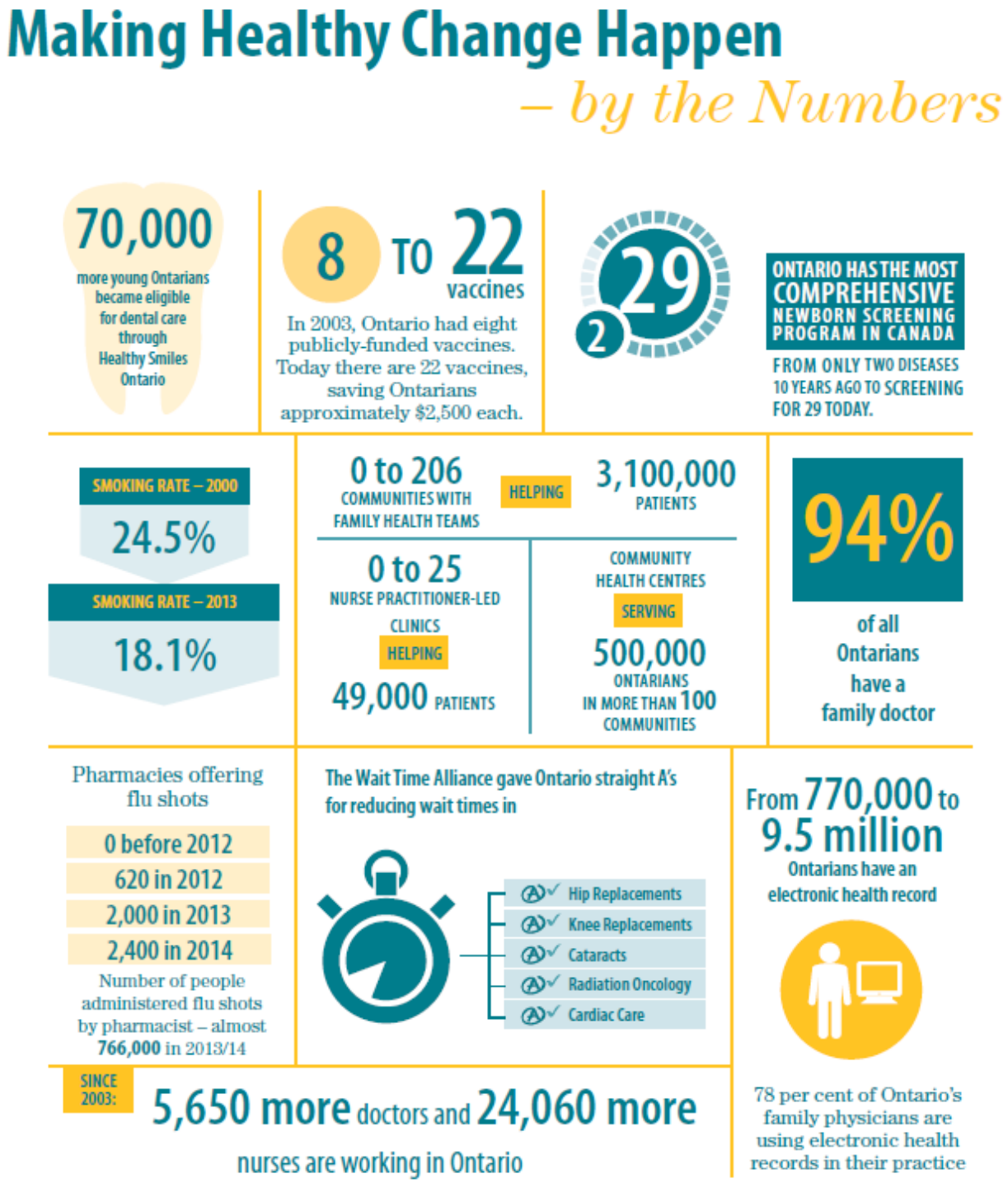
THEMES	EXCEPTIONAL PEOPLE	WORKING TOGETHER	OUTSTANDING CARE
DESCRIPTION	We will ensure we have highly-skilled, capable and passionate staff, physicians and volunteers who care for the person (NOT JUST THE DIAGNOSIS) as well as for the success of the team.	We will create a seamless way for patients to access the right care from one system.	We will provide our patients with access to the highest quality care as close to home as possible and will respect their decisions.
MEASURES	• Engagement survey results for staff, physicians and volunteers	• Working with partners to develop shared measures such as caring for patients in the most appropriate place (ALTERNATE LEVEL OF CARE (ALC)), unplanned readmissions and admissions to SAH where a different approach to care could have prevented that admission (AMBULATORY CARE SENSITIVE ADMISSIONS) • Degree to which patient information is available electronically across the community and across the region (ELECTRONIC MEDICAL RECORD ADOPTION MODEL (EMRAM))	• Patient satisfaction results • Delivering care here when we can do so in a quality and safe way • Best performing hospital on quality measures including Hospital Acquired Infections, wait times, Hospital Standard Mortality Rate (HSMR)
PRIORITY INITIATIVES	**iCare Way** - Build on investments to create a values-based culture, in which staff, physicians and volunteers enjoy their roles, are proud to work at the hospital and drive continuous improvement. **Best Leadership** - Enhancing investments in leadership development with an early focus on exceptional physician leadership. We will ensure we have the ability to attract, retain and develop leaders. **Best Skill** - Our recruitment and education efforts will focus on values and skills to meet our patient' needs. We will augment our clinical education and research capability.	**Information & Information Technology** - Improve access to the information needed to provide care in ways that impact the patient both within SAH and across the system. **Community / Regional Partnerships** - Continue to work with partners to develop community and regionally based services with a focus on: • Committing to be an active partner in a proactive approach for population health management in our community and region, beginning with achieving the Health Link objective of improving care of patients with highest needs; • Leading renewed work to improve and integrate Mental Health & Additions service delivery; • Developing a sustainable Alternate Level of Care (ALC) solution; and • Maximize our opportunity to align services to the needs of patients on a hub (sub-LHIN) basis.	**Patient and Family First Culture** - Involving patient and family advisors in key decisions in the organization, ensuring patients and their families have timely access to information and can have their questions answered and seeing patients and their families as part of the health care team. **Senior-friendly Health Care** - Understanding and addressing the service needs of Algoma's growing geriatric population. **Transforming Care** - Providing more services through ambulatory and mobile care instead of an inpatient setting, standardizing the delivery of care. **Care Close to Home** - Meeting the needs of our patient population by ensuring the care that should be provided here is and creating strategic alliances with local and provincial partners for care that should be provided elsewhere. **Leveraging our Assets** - working with others to leverage our assets to support the successful execution of all of our other strategies.

VISION

We will be recognized as the best hospital in Canada and an active partner in the best community health care system in the country.

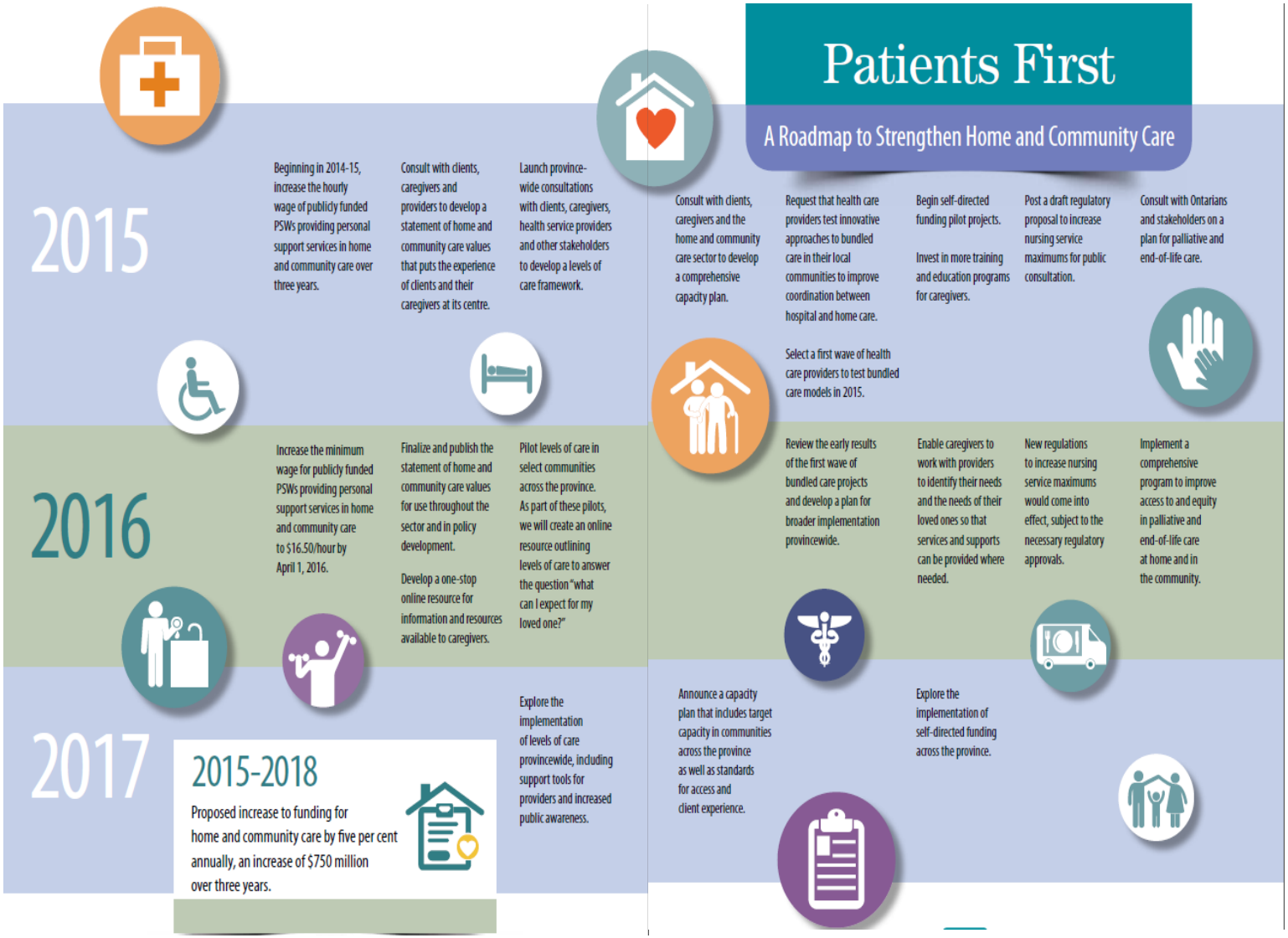
iCare

3 Patients First: Ontario's Action Plan for Health Care. Making Health Change Happen – by the numbers

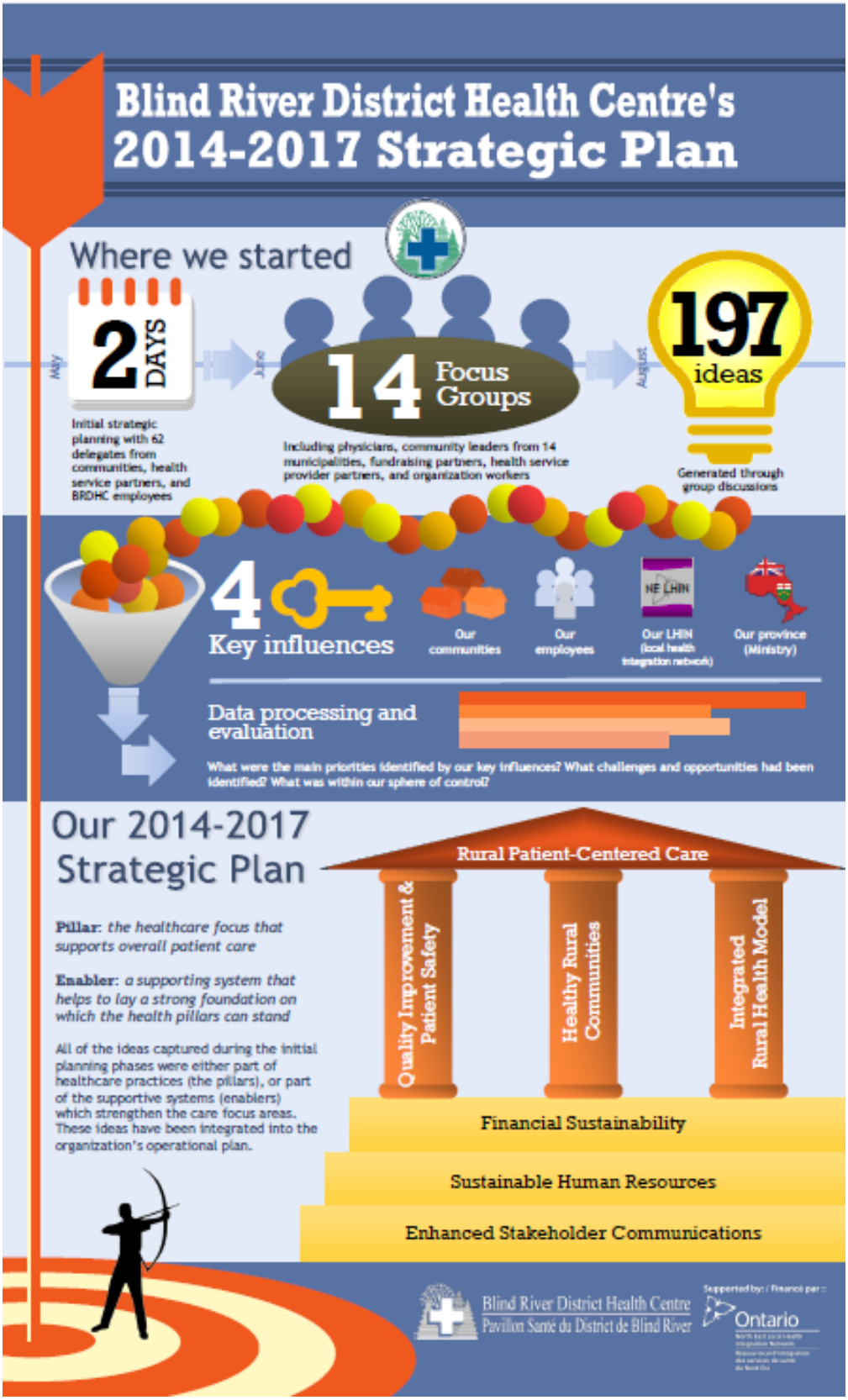


Source: Ministry of Health & Long-Term Care (2015). *Patients First: Ontario's Action Plan for Health Care.* February http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_patientsfirst.pdf

4 Patients First – A Roadmap to Strengthening Home and Community Care



5 Blind River District Health Centre's 2014-2017 Strategic Plan



5 Health Sciences North – By The Numbers

6 North East LHIN's Strategic Plan 2016 – 2019 – Integrated Health Services Plan

North East **LHIN**

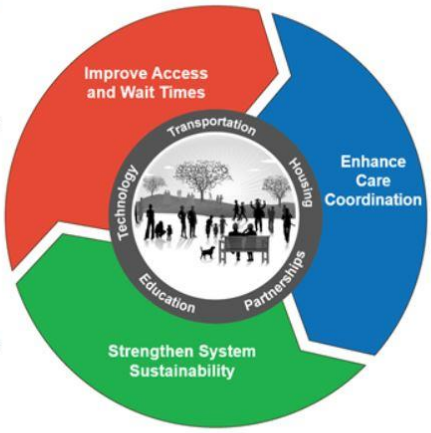
Search/Recherchez

About Us | Home and Community Care | Our Priorities | Community Engagement | Accountability | Governance

Home > Goals and Achievements

IHSP Priorities

Further to the input of thousands of Northerners through many engagement efforts, the **North East LHIN's strategic plan for 2016-2019** is now complete. Known as the Integrated Health Service Plan (IHSP), the plan is aligned with the Ministry of Health and Long-Term Care's ***Patients First: Ontario's Action Plan for Health Care (Feb. 2015)***. This IHSP outlines three priorities to guide the work of the NE LHIN in its partnership work with fellow Northerners to strengthen the Northeastern Ontario health care system.



In preparation for this important Northeastern Ontario strategic health care plan, the NE LHIN held more than 500 engagements with Northerners since 2013, including 43 IHSP-specific engagements; received more than 1,000 responses to a November 2014 survey ***Perceptions of Northeastern Ontario Health Care System***; and reviewed more than 800 responses to a survey ***Validating Northeastern Ontario's 2016-2019 Health Care Priorities.***

Based on what we heard, the 2016-2019 priority areas to improve patient care and respond to the needs of Northerners are:

- **Improve Access and Wait Times**
- **Enhance Care Coordination**
- **Strengthen System Sustainability.**

In addition, the LHIN will work with partners to focus on social determinants of health, such as transportation and housing, in addition to **technology**, and education, to move priorities forward.

Driving **system quality** and value, enhancing the patient experience, and improving population health while recognizing cultural diversity, particularly for **Francophone** & **Aboriginal people** will guide all NE LHIN work.

To read our *Integrated Health Service Plan, 2016-2019*, **click here.**

Our 2016-2019 IHSP Areas of Care under each priority include:

Primary Care

- Primary Care in the North East LHIN
- Health Links
- Northeast Hip and Knee Replacement Program (NE HKRP)
- Physician Office Integration
- Recruitment and Retention of Health Human Resources
- Timmins Francophone Primary Care Collaborative Committee

Specialty Care

- Behavioural Supports Ontario (BSO)
- Diabetes
- Maternal-Child Health Care
- One Person. One Record. One System Initiative
- Telehomecare

7 North East LHIN's Strategic Plan 2016 – 2019 (Continued) – Integrated Health Services Plan

Acute Care

- Emergency Department Wait Times
- Patient Flow / Alternate Level of Care (ALC)

Home & Community Care

- Home and Community Care in the North East LHIN
- Housing and Health Supports
- Non-Urgent Patient Transportation
- North East Home and Community Care Network
- Stay On Your Feet

Mental Health & Addictions Care

- Dementia in the North East LHIN
- Mental Health and Addictions Care in the North East LHIN

Rehabilitative Care

- Physiotherapy
- Rehabilitative Care

Long-Term Care

- Long-Term Care in the North East LHIN

Palliative Care

- Hospice Palliative Care

8 NE LHIN LIFE EXPECTANCY, MORTALITY AND POTENTIAL YEARS OF LIFE LOST

LIFE EXPECTANCY, MORTALITY AND POTENTIAL YEARS OF LIFE LOST

	NORTH EAST	Ontario	Comment
Life expectancy at birth (yrs), 2007/09	79.0	81.5	2nd lowest in province
Life expectancy at age 65 (yrs), 2007/09	18.9	20.3	Lowest in province
Mortality (2007)			
Total deaths, 2007	5,330	86,945	
All cause mortality rate per 100,000 population	931.2	679.6	2nd highest in province
% of deaths that were premature (age <75)	43.8%	37.7%	2nd highest in province
Top 10 leading causes of death, 2007 (rate per 100,000)			
Ischaemic heart disease	173.3	110.9	Highest in province
Cancer of lung & bronchus	77.2	48.7	Highest in province
Chronic lower respiratory diseases	51.2	28.3	Highest in province
Dementia and Alzheimer disease	45.6	42.0	
Cerebrovascular diseases	41.2	41.5	
Diabetes	38.8	23.5	Highest in province
Cancer of colon, rectum, anus	32.1	24.5	Highest in province
Cancer of lymph, blood & related	28.1	19.6	Highest in province
Diseases of urinary system	17.3	16.1	
Cancer of breast	17.1	15.3	
Age specific mortality rate, 2006-07 average			
00-19	59.0	40.4	Highest in province
20-44	119.3	71.0	Highest in province
45-64	579.5	419.2	Highest in province
65-74	2,043.7	1,639.2	Highest in province
75+	7,293.0	6,619.9	2nd highest in province
Potential Years of Life Lost (PYLL), 2007			
PYLL rate, per 100,000 population 0-74	6,838.2	4,628.1	Highest in province
Top 10 Leading causes of PYLL (rates per 100,000 age 0-74)			
Ischaemic heart disease	868.9	456.6	Highest in province
Cancer of lung & bronchus	576.3	341.3	Highest in province
Intentional self harm	506.4	269.7	2nd highest in province
Transport accidents	396.9	231.9	Highest in province
Perinatal conditions	240.2	288.7	
Cirrhosis and other liver diseases	230.4	126.7	Highest in province
Cancer of lymph, blood & related	207.8	145.0	Highest in province
Accidental poisoning	202.7	136.0	
Cancer of colon, rectum, anus	200.8	152.9	2nd highest in province
Diabetes	186.9	114.3	

Source: Local Health Integration Network (2012). Integrated Health Service Plan 2013-2016 - September

LIST OF ACRONYMS AND ABBREVIATIONS

ABG	Arterial Blood Gas
ACMPR	Access to Cannabis for Medical Purposes Regulation
ADCP	Algoma District Cancer Program
ADL	Activities of Daily Living
ADRP	Algoma District Renal Program
AHAC	Aboriginal Health Access Centre
ALC	Alternative Level of Care
AODA	Accessibility for Ontarians with Disabilities Act 2005
ARO	Antibiotic Resistant Organism
ASP	Antimicrobial Stewardship Program
BMV	Barcode Medication Verification
BORN	Better Outcomes Registry & Network
BPS	Broader Public Sector
BPSECA	Broader Public Sector Executive Compensation Act, 2014
BRDHC	Blind River District Health Centre
CCAC	Community Care Access Centres
CCO	Cancer Care Ontario
CCS	Canadian Cancer Society
CDI	*Clostridium difficile* infection
CHF	Congestive Heart Failure
CKD	Chronic Kidney Disease
CLI	Central Line Infection
CMLTO	College of Medical Laboratory Technologists of Ontario
cNEO	Connecting Northern and Eastern Ontario
COPD	Chronic Obstructive Pulmonary Disease

CPE	Carbapenemase Producing Enterobacteriaceae
CPOE	Computerized Physician Order Entry
CSS	Community Support Service
CT	Computed Tomography
CVA	Cerebrovascular Accident
ECFAA	Excellent Care for All Act, 2010
eMAR	Electronic Medication Administration Record
eMed Rec	Electronic Medication Reconciliation
EMR	Electronic Medical Records
ER	Emergency Department
ERAS	Early Recovery After Surgery
EUS	Endoscopic Ultrasound
FHTs	Family Heath Teams
FNIM	Aboriginal Cancer Strategy
GHC	Group Health Centre
HAI	*Hospital Acquired Infections*
HBAM	Health Based Allocation Model
HD	Hemodialysis
HH	Hand Hygiene
HHR	Health Human Resource
HIGs	HBAM Inpatient Groups / Health Based Allocation Model
HIPA	Health Information Protection Act, 2016
HIS	Health Information System
HOODIP	The Hospitals of Ontario Disability Income Plan
HOOPP	Healthcare of Ontario Pension Plan
HQO	Health Quality Ontario
HR	Human Resources

HSFR	Health System Funding Reform
HSN	Health Sciences North
IADL	Instrumental Activities of Daily Living
ICU	Intensive Care Unit
IMG	International Medical Graduates
IPAC	*Infection Prevention and Control*
IPC	Infection Prevention and Control
IQMH	Quality Management in Healthcare
ISD	Ischemic Heart Disease
JHIC	Joint Health and Safety Committees
LGIC	Lieutenant Governor in Council
LHSC	London Health Sciences Centre
LHSIA	Local Health System Integration Act, 2006
LTCH	Long-Term Care Home
LTC	Long-term Care
MAID	Medical Assisted Dying
MH&A	Mental Health and Addictions
MPP	Minister of Provincial Parliament
MMAR	Marihuana Medical Access Regulations
MMPR	Marihuana for Medical Purposes Regulations
MOHLTC	Ministry of Health and Long Term Care
MOL	Ministry of Labour
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphylococcus Aureus
NE LHIN	North East Local Health Integration Network
NEO KIDS	North Eastern Ontario Health Centre for Kids
NFPCA	Not-for-Profit Corporations Act, 2010

NODA	Northern Ontario Service Deliverers Association
NOSM	Northern Ontario School of Medicine
NPLC	Nurse Practitioner Led Clinics
ODB	Ontario Drug Benefit Program
OHA	Ontario Hospital Association
OLIS	Ontario Laboratories Information System
OMA	Ontario Medical Association
ONA	Ontario Nurses Association
OP	Out Patient
OPSEU	Ontario Public Service Employees Union
OPTN	Organ Procurement and Transplantation Network
OR	Operating Room
ORN	Ontario Renal Network
ORPP	Ontario Retirement Pension Plan
OSA	Obstructive Sleep Apnea
OSCE	Objective Structured Clinical Examination
OTN	Ontario Telemedicine Network
PA	Physician Assistant
PBF	Patient-based Funding
PIDAC	Provincial Infectious Disease Advisory Committee
PFA	Patients First Act
PFT	Pulmonary Function Test
PFAC	Patient Family Advisory Committee
PHI	Protected Health Information
PHIPA	Personal Health Information Protection Act
POC	Point of Care Testing
POI	Physician Office Integration

PSHSA	Public Service Health and Safety Association
PYLL	Potential years of Lost Life
QBP	Quality Based Procedure
QCC	Quality of Care Committee
QCIPA	Quality of Care Information Protection Act
QIP	Quality Improvement Plan
QMP	Quality Management Partnership
RFPU	Regional Forensic Pathology Units
RN	Registered Nurse
ROP	Required Organizational Practices
RWMS	Residential Withdrawal Management Services
SAH	Sault Area Hospital
SENIC	Study on the Efficacy of Nosocomial Infection Control
SSMAMA	Sault Ste. Marie Academic Medical Association
TCU	Transitional Care Unit
UHN	University Health Network
VAP	Ventilator Associated Pneumonia
VDI	Standardized Desktop Delivery
VRE	Vancomycin Resistant Enterococci