Englehart and District Hospital

Strategic Plan 2014-2017

January 2014

1.0 EXECUTIVE SUMMARY

A corporation's strategic directions and objectives are designed to propel the organization toward its stated vision. It is the vision of Englehart and District Hospital to be:

- A leader in Quality health care services.
- A collaborative workplace for the entire health care team.
- An innovative and valued partner in our community, respected by our peers.

Englehart and District Hospital has chosen three broad strategic directions to guide its efforts towards achieving this vision over the next three years. Each of these directions are supported by objectives, which will be further elaborated through action plans. Each direction is also assigned a goal that will be used to measure the success of that direction.

Strategic Direction 1: Quality Culture – The Hospital embraces a culture of Quality which is patient centered, utilizes best practices and optimizes health outcomes.

Objective 1a: All Accreditation Standards of excellence will be met to improve patient care and health outcomes.

Objective 1b: Meet all "Excellent Care for All Act" legislated requirements annually.

Objective 1c: Create a quality culture that will enable the reporting of critical events and near misses by focusing on process improvements and staff accountability.

Objective 1d: Continuously improve patient safety by benchmarking against best practices, redesigning processes and by continuously measuring and communicating result.

Big Hairy Audacious Goal: Exemplary standing by Accreditation Canada in the 2015 Survey.

Strategic Direction 2: Effective Resourcing - Englehart and District Hospital will continue to provide the entire range of hospital services consistent with the Ministry of Health and Long Term Care's Joint Policy and Planning Committee recommended core services for small hospitals.

Objective 2a: Ensure sufficient physician resources to meet the community's needs.

Objective 2b: Ensure sufficient staff human resources to meet operational needs.

Objective 2c: Operate within the established operating and capital budgets while investigating other options.

Objective 2d: Investigate and implement, where it is beneficial to do so, opportunities for horizontal and vertical integration of services.

Big Hairy Audacious Goal: Advance the new Health Care Facility project to gain Ministry of Health and Long Term Care commitment for a full service, geocentric facility for the district.

In 2006, the Joint Policy and Planning Committee (JPPC) recommended to the Ministry of Health and Long Term Care (the Ministry) the following list of core services for small hospitals:

- An Emergency Department prepared to provide care, or stabilize and transfer, medical, surgical and mental health patients entering via the department ;
- Acute Care Inpatient Medical Beds;
- General Practitioners/Family Physicians supported by broadly-trained Nurses;
- Inpatient Allied Health Services (Physiotherapy, Clinical Nutrition, Occupational Therapy, Respiratory Therapy, Speech Pathology and Pharmacy); and
- Laboratory, Ultrasound, General Radiography and Non-invasive Cardiology.

The Board of Directors has determined that Englehart and District Hospital will continue to operate inpatient acute care services as part of its commitment to fulfill the mandate of a small hospital, as defined by the JPPC, and as highly valued by the community.
It is clear that the recruitment and retention of physicians is a top priority as shortages have a negative impact on patient care, facility optimization and costs.

Strategic Direction 3: Community Leadership - Englehart and District Hospital will continue to work with other health care, social services, and planning partners to enhance services for seniors across the spectrum of care, specifically focusing on long term care.

This requires the organization to focus on three distinct areas:

Objective 3a: Pursue the establishment of long term care spaces

Objective 3b: Link with community partners to provide greater support for residents in their own homes, through such services as: outreach clinical services, home support, and meals on wheels. Explore the feasibility of alternate bed types, for example: rehab and assisted living.

Objective 3c: Refine existing hospital services.

Big Hairy Audacious Goal: Lead the development of a respectful Assisted Living Community.

The 2011 Census supports the need for enhanced services for seniors in Timiskaming is undeniable. In the Englehart area, 26% of the population is over age 65, where only 15% of the Ontario population is over age 65. The Timiskaming District figure is 19%.

With out-migration of local young people to southern cities for higher education, first, then employment, the local population consists largely of elder citizens. The Census also indicates

that the largest population group in the Timiskaming District is the 65-74 age group, yet Ontario's largest group is the 45-49 age group.

The local long term care facility is a Schedule C facility with significant structural issues. It is understood that this facility's license will not be renewed unless major capital investments are made. Economies of scale in operating the current, 48-bed standalone facility make it unlikely that the required capital investment will have sufficient payback to retain private sector involvement in provision of these services locally.

There is a notable absence of privately funded assisted living or 'retirement home accommodation' within the District. As with residential long term care, this reflects the challenge of achieving economies of scale and the difficulty for private organizations to earn a profit by providing this service to small populations. It is a significant factor contributing to higher local per capita requirements for long term care beds.

Given the Ministry of Health and Long Term Care's goal of aging at home, as well as current gaps in district health services, it seems prudent to optimize the existing Hospital Infrastructure while developing a plan to build a new multi-use and long-term care facility.

Englehart and District Hospital is ideally positioned to lead and participate in these initiatives for the following reasons:

- Adding long term care places to the existing complement of acute care and complex continuing care beds allows for greater economies of scale in administrative and support services. It likely makes the best sense, financially.
- Organizational partners view the hospital and its management staff very positively, acknowledging them as leaders. Relationships with other private and public partners are well established and will serve as the foundation for the work required to enhance services for seniors.
- Local residents have demonstrated time and again their overwhelming capacity to contribute to capital fundraising campaigns - for hospital equipment, and for hospital renovations, and for related projects to accommodate first the medical staff and then the Family Health Team.

There are already well established models within North East Ontario to refer to, both from the perspective of development and implementation of long term places in conjunction with an acute care facility, and in relation to their ongoing operations. These include Espanola Regional Hospital and Health Centre, Blind River District Health Centre, and Services de santé de Chapleau Health Services.

On behalf of the community that it serves, the Board of Directors of Englehart and District Hospital will engage with the Ministry, the North East LHIN, and local organizational partners to determine how to best serve the needs of local seniors through the creation of an Englehart District Integrated Health Care Facility. At the same time, the organization will work with its

partners to refine the services offered internally to seniors and to provide greater support for residents to sustain them in their own homes for as long as possible.

INDEX

2.0 ACKNOWLEDGEMENTS

The 2011-2013 Strategic Plan was developed with the guidance of Sharon Van Valkenburg and involved many community and staff groups, culminating in a two day planning session attended by Senior Management and many Board of Directors members. The quality of this Strategic Plan was acknowledged by Accreditation Canada in its quality audit of our facility. As a result, the development of the 2014-2017 Strategic Plan was able to be more focused and during the session held by Senior Management and the Board of Directors. The Board of Directors has endorsed this Strategic Plan to guide the Englehart and District Hospital for the next three years.

3.0 INTRODUCTION

This Strategic Plan documents the strategic directions that Englehart and District Hospital has chosen for the three year period beginning January 2014. It summarizes the significant internal and external factors that have led to these decisions

3.1 Background Information

Englehart and District Hospital (EDH) is a fully accredited 30-bed facility located in Englehart, Ontario. Originally established in 1955, EDH is a primary care hospital providing a wide range of services, including:

- 24 hour Emergency Room coverage,
- General Medical inpatient beds,
- Complex Continuing Care,
- Diagnostic Imaging Services,
- Laboratory Services,
- Physiotherapy,
- Respiratory Therapy, and
- Occupational Therapy

Located in Central Timiskaming District, Englehart and District Hospital serves a population of approximately 8,100 people located in Towns and Townships throughout the area. The hospital is situated in Ontario's North East LHIN planning region, within the Timiskaming planning area.

The local economy is comprised mainly of agricultural and forestry-related businesses, with a large oriented strand board plant located on the periphery of the Town of Englehart.

3.2 Strategic Planning Process

The strategic planning process included a number of elements designed to develop a comprehensive understanding of the hospital and the environment in which it exists.

- An extensive review of the planning environment was undertaken, to ensure that this strategic plan was developed in context. This included review of the priorities of the Ministry of Health and Long Term Care (the Ministry), the North East LHIN, Network 13, and the Ontario Hospital Association Small Hospitals Summit. This review also included a summary of key legislative changes as well as internal reviews such as the Englehart and District Hospital Operations Plan and departmental reviews.
- The most current external source data was reviewed to obtain information concerning the population served.

- The organization's financial and statistical data was mined to develop a comprehensive summary of current programs and services.
- The results of external, quality-oriented third party reviews were summarized and integrated.

The Board of Directors met October 7, 2013 to consider the findings from the processes outlined above and to determine the hospital's strategic directions for the next three years. As a result of this process, this Strategic Plan identifies opportunities and threats in the external environment that present challenges for EDH. It also defines the organization's internal strengths and weaknesses. Considering all of these factors, the Plan identifies a number of strategic directions that the Board of Directors has chosen to guide the hospital's actions from 2014 through 2017.

4.0 EXTERNAL ENVIRONMENT

This section of the Strategic Plan begins with an orientation to the planning and policy environment in which Englehart and District Hospital currently operates. It provides information concerning nature of the population served the hospital, and the health needs of this community. Key health service providers for this community are identified, with their services briefly highlighted. The unique characteristics of the hospital's funding environment and labour sources are also documented.

A number of data sources have been used to develop this profile of the external environment, including the most recent information available from Statistics Canada from the 2011 census, the Timiskaming Health Unit Catchment Area Health Profile from January 2013 and the Health Links demographic census and utilization profile (September 2013).

Unfortunately, information is not always available at the local level. In these instances, information has been provided for Timiskaming District as a whole and is identified as such.

4.1 Planning Bodies and Their Priorities

Roughly 82% of the Englehart and District Hospital's total revenues are flowed directly by Ontario's Ministry of Health and Long Term Care. Faced with an aging population and increasing health care costs, the Ministry is challenged to meet the population's needs for services at a price that Ontarians are prepared to support. A key priority for the Ministry of Health and Long Term Care is aging at home, which is derived from their right care, right time, right place strategy. This priority has a significant impact on Hospital planning.

The North East LHIN supports this initiative in their strategic plan.

In planning services for the community for the next three years, Englehart and District Hospital has made the assumption that there will be:

- Increasing patient demands, expectations and knowledge
- Continuing, significant increases in the cost of providing hospital services
- Limited opportunities to achieve further efficiencies in current hospital operations
- Challenges in achieving economies of scale and scope
- Severe pressure on the availability of government financial resources
- Aging workforce and population
- Skills shortages in health human resource pools

These planning assumptions are consistent with those used by the Ministry and regional health services planning bodies.

The planning priorities of the Ontario Ministry of Health and Long Term Care are identified in the Ontario's Action Plan for Health Care. They focus on commitments to:

- Keeping Ontario Healthy
- Faster access to stronger family Healthcare
- Right care, right time, right place.

The Ministry's Hospital Annual Planning Submission (HAPS) process includes guidance for hospitals in relation to their own planning exercises. This process directs hospitals to focus on:

- Population need and patient experience
- Overall benefit to the system of health care
- Transparency – demonstration of engagement of all stakeholders (patients, residents, physicians, staff, and health service providers) at the appropriate time and in a positive manner
- Sustainability of financial, human and physical resources.

The HAPS process encourages all hospitals to:

- Optimize operational efficiencies
- Realign or remove health services not consistent with:
  - LHIN Integrated Health Services Plan and Ministry priorities
  - Hospital Strategic Plan
- Transfer services more appropriately delivered in the community
- Identify and evaluate integration opportunities
- Realign or remove low demand health services

The Joint Policy and Planning Committee (JPPC) was a partnership through which the Ministry and the Ontario Hospital Association worked jointly to develop optimal health care policy, strategic planning and management decision for the Ontario hospital system. In October of 2006, this group outlined the recommended core services for small hospitals. These include:

- An Emergency Department prepared to provide care, or stabilize and transfer, medical, surgical and mental health patients entering via the department
- Acute Care Inpatient Medical Beds
- General Practitioners/ Family Physicians supported by broadly-trained Nurses
- Inpatient Allied Health Services (Physiotherapy, Clinical Nutrition, Occupational Therapy, Respiratory Therapy, Speech Pathology and Pharmacy)
- Laboratory, Ultrasound, General Radiography and Non-invasive Cardiology

The JPPC further stated that in some communities it may be appropriate for small hospitals to provide Ambulatory Clinics and outpatient Allied Health Services. However, approval for these services would require extensive evidence, discussion and consideration of the community's unique circumstances.

In positioning the small hospital within its community, the JPPC indicated that 'The reach of rural hospitals, however, may ideally extend in both directions; into the community and also into urban centres: an access hub for its community in both directions.'

Englehart and District Hospital is included in the North East LHIN planning region. The North East LHIN established four strategic priorities for the region for the three year period 2013-2016 in its integrated health Services Plan. These priorities focus on:

- Increase Primary Care Coordination
- Enhance care coordination and transitions to improve the patient experience
- Make mental health and substance abuse treatment services more accessible
- Target the needs of culturally diverse population groups

Within the North East Region, Englehart and District Hospital aligns itself with a group of hospitals and health care organizations collectively referred to as Network 13. This group includes agencies within Timiskaming and Cochrane Districts and through its involvement allows Englehart and District Hospital to contribute and benefit from experiences from all health service providers from the James Bay coast to Englehart and from Chapleau to the Quebec Boarder.

Englehart Hospital is also a member of the Timiskaming Health Link. This multiservice provider group will focus on the highest 5% users of health care services with a goal of improving care transitions and thereby improving the quality and cost of care to these patients.

4.2 Key Legislative Changes

This Strategic Plan will be executed within a legislative environment that continues to challenge hospitals to become ever more accountable, now linking compensation for key administrative staff to achievement of the hospital's performance targets.

The Excellent Care for All Act was enacted in June 2010 and requires hospitals to:

- Establish a Quality Committee reporting to the Board, with specific responsibilities
- Every two years survey patients and their caregivers, and employees
- Develop a patient declaration of values
- Define a patient relations process that meets regulations
- Make a quality improvement plan available to the public annually, as defined by regulations
- CEO compensation connected to achievement of performance targets

This Act is complemented by new Public Hospitals Act Ontario Regulation 156/10, which now requires that any employees and medical staff who are members of the Board are non-voting members. It also establishes a requirement for a system for the disclosure, analysis and avoidance of critical incidents.

The Public Sector Compensation Restraint to Protect Public Service Act was also enacted in June 2010. This Act freezes rates of pay and pay scales, benefits, and perquisites for select employees from March 24, 2010 to March 31, 2012. This Act was later expanded to ensure these freezes were in place until the Provincial Government balances its budget, expected in 2018.

4.3 Geography

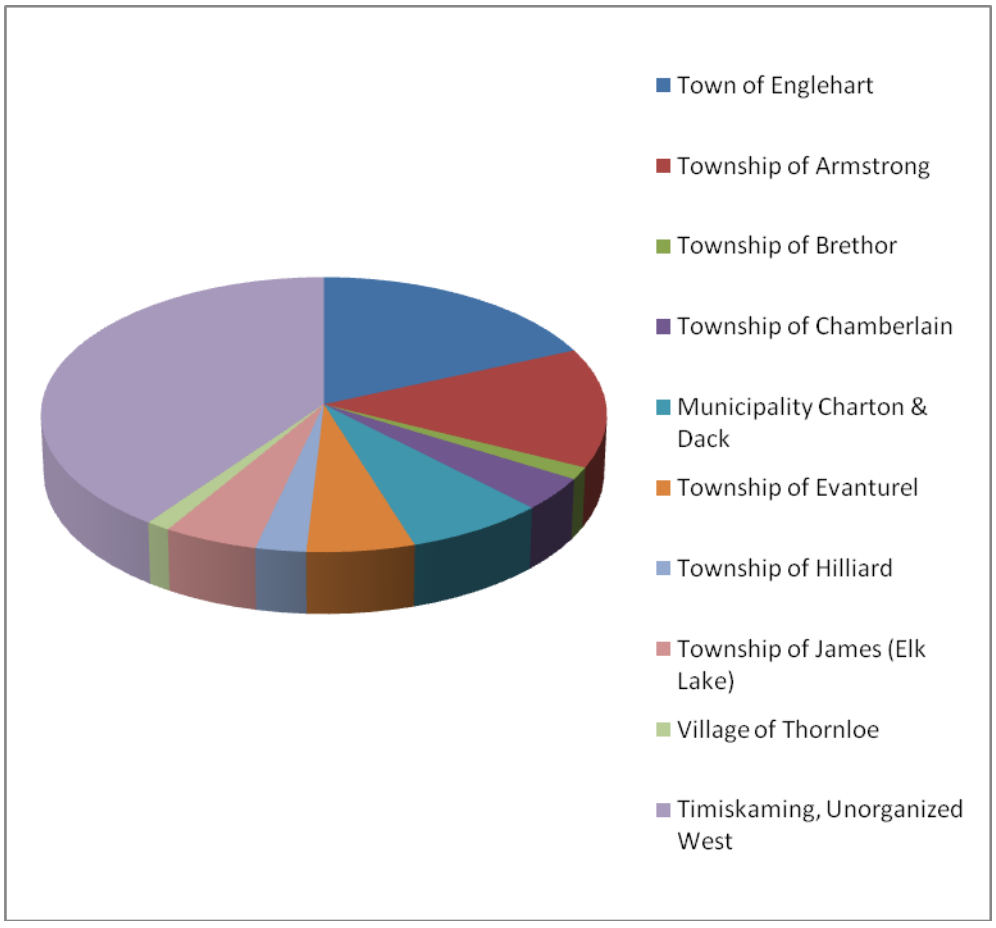
The catchment area of Englehart and District Hospital includes approximately 8,000 people located in Central Timiskaming District, according to the 2011 Statistics Canada Census. Geographically, this area includes: the Town of Charlton, the Town of Englehart, the Village of Thornloe, seven Townships (Armstrong, Brethour, Chamberlain, Charlton and Dack, Evanturel, Hilliard, and James), and the Unorganized West Part of the District. The catchment area population includes approximately 25% of the 32,624 residents of Timiskaming District.

Figure 2: Englehart District Hospital Within Timiskaming District

Roughly 48% of this local population is concentrated in the Town of Englehart (1,554), the Municipality of Charlton and Dack (671) the Town of Elk Lake (424), and the Township of Armstrong (1,216), while the remaining 52% represents a mostly rural population. The population density for the Englehart Hospital catchment area is 25% of the Timiskaming District. Between 2006 and 2011 the population of the catchment area decreased by 242 people.

Municipality	Population 2006	Population 2011	% change
Town of Englehart	1,509	1,544	3.00%
Township of Armstrong	1,155	1,216	5.30%
Township of Brethor	117	129	10.30%
Township of Chamberlain	322	297	-7.80%
Municipality Charlton & Dack	613	671	9.50%
Township of Evanturel	473	452	-4.40%
Township of Hilliard	222	204	-8.10%
Township of James (Elk Lake)	414	424	2.40%
Village of Thornloe	105	123	17.10%
Timiskaming, Unorganized West	3,297	2,925	-11.30%
Total	**8,227**	**7,985**	**-2.94%**
Timiskaming District Totals	33,283	32,634	-1.95%
Ontario Totals	12,160,282	12,851,821	5.69%

Source: Statistics Canada, 2006 and 2011 Census Data



4.4 Demography

4.4.1 Age

As of 2011, 26.0 % of Englehart & District Hospital's catchment population and 19.2% of Timiskaming District residents are 65 years of age and older, as compared to just 14.6% of Ontario's population, on average.

	Englehart	Dis. Of Tim.	Ontario
Population over 65	405	6,275	1,878,325
Percentage of total	26.0%	19.2%	14.6%

Source: 2011 Census

The North East LHIN has projected the age distribution for the Timiskaming Planning Area as of 2031, forecasting that 45.3% of the local residents will be 55 years of age or older. (NE LHIN Demographic and Health Profile, based on Statistics Canada Population Estimates for 2007)

As a result of chronic diseases, senior citizens make greater use of physician services, hospital services, and home care services. Therefore, services directed to sustaining the health of this population of senior citizens should increase quality of life while decreasing costs to the health system overall, through reduced use of physicians, hospitals and home care.

4.4.2 Francophone Population

Statistics Canada data from 2011 indicate that while only 5% of the residents in the Englehart area speak French most often at home, 23.6% of the District of Timiskaming speaks French most often at home. Select Timiskaming District health service organizations are designated to provide services in French, under the French Language Health Services Act.

2011 Census	Englehart	% of Total	Tim. Dist.	% of Total	Ontario	% of Total
Total Responses	1,500		32,105		12,722,060	
English	1,395	93.0%	23,180	72.2%	8,677,040	68.2%
French	75	5.0%	7,580	23.6%	493,300	3.9%
Selected Aboriginal	0	0.0%	15	0.0%	15,625	0.1%
Non-Official	25	1.7%	895	2.8%	3,264,435	25.7%
Source: Statistics Canada, 2011 Census Data						

4.5 Behaviour and Health Practices

4.5.1 Smoking

As illustrated in the chart below there was a dramatic decline in the proportion of the population who smoke daily, both in Timiskaming District and in Ontario between 200 and 2010. Most recent data indicates that the proportion of District residents who smoke daily has increased to 17.4% from 14.9% in 2010, while the rate for Ontario remained virtually unchanged at 14.5%.

	Timiskaming Dist	Ontario
2013	17.4%	14.5%
2010	14.9%	14.4%
2005	21.4%	15.4%
2003	23.6%	16.7%
2000	34.9%	22.7%

Source: THU Health Profile on Statistics Canada 2013

4.5.2 Alcohol Consumption

In 2009, Statistics Canada changed the methodology for calculating the prevalence of heavy drinking. Starting in 2009, the denominator for the indicator includes all the population aged 12 and over. In data released before 2009, the denominator included only the population who reported having had at least one drink in the past 12 months. This change was implemented to produce more comparable rates over time and is more consistent with methods used in calculating other indicators; however, increasing the population in the denominator reduces the estimated rates overall.

As a result, the data presented in the following table between 2003 and 2010 is not comparable year to year. The 2010 and 2013 data is comparable and reveals that heavy drinking has increased in both Timiskaming District and the Province as a whole. Timiskaming District rate is lower than the average for the province.

	Timiskaming Dist	Ontario
2013	14.1%	15.9%
2010	11.7%	15.6%
2003	26.0%	20.5%
2000	22.1%	19.3%

Source: THU Health Profile on Statistics Canada 2013

Note: Sourced from Canadian Community Health Survey, Statistics Canada 2009/2010. Population aged 12 and over who reported having 5 or more drinks on one occasion, at least once a month in the past year.
Heavy drinking refers to having consumed five or more drinks, per occasion, at least once a month during the past year. This level of alcohol consumption can have a serious health and social consequence, especially when combined with other behaviours such as driving while intoxicated.

4.5.3 Overweight and Obesity

From 2001 to present, there has been an increase both in Timiskaming District and in the province in the proportion of the population who are overweight or obese. Within Ontario, this increase has been gradual - increasing from 47.5% to 52.0% an increase of less than 1-%, over the past 12 years, while Timiskaming District increased almost 30% over the same period.

	Tim. District Overweight	Tim. District Obese	Tim. Dist Total		Ontario Overweight	Ontario Obese	Ontario Total
2013	37.9%	31.4%	69.3%		34.0%	18.0%	52.0%
2010	49.9%	27.4%	77.2%		34.0%	17.4%	51.4%
2005	41.0%	18.6%	59.6%		33.8%	15.2%	49.0%
2003	33.6%	20.8%	54.4%		33.3%	14.8%	48.1%
2001	37.2%	16.6%	53.8%		32.8%	14.7%	47.5%

Percentage of change from 2010-2103

Total of Overweight and Obese		
	Tim. District	Ontario
2013	69.3%	52.0%
2010	77.2%	51.4%
difference	-7.9	0.6

Note: Body mass index (BMI) is a method of classifying body weight according to health risk. According to the Work Health Organization (WHO) and Health Canada guidelines, health risk levels are associated with each category.

Weight Categories

- Normal Weight= least health risk
- Underweight & Overweight= Increased Health Risk
- Obese, Class 1= high health risk
- Obese Class 2 = very high health risk
- Obese Class 3 = extremely high health risk

Body Mass Index (BMI) is calculated by dividing the respondent's body weight (in KG) by height (in Metres) squared

- Less than 18.50 (underweight)
- 18.50 to 24.99 (normal weight)
- 25.00 to 29.99 (overweight)
- 30.00 to 34.99 (obese, Class 1)
- 35.00 to 39.99 (obese, Class 2)
- 40.00 or greater (obese, Class 3)

4.5.4 Disease Prevention and Early Screening

Rates for influenza immunization for District residents are lower than those for Ontario overall but PAP tests are roughly the same for both. However, mammogram rates for local residents lag significantly in comparison to Ontario norms.

Figure 8: Percentage of Timiskaming District Residents Who Participate in Disease Prevention and Early Screening Initiatives

	Tim. District 2010	Tim. District 2013		Ontario 2010	Ontario 2013
Influenza Immunization	38.9%	35.1%		35.3%	40.0%
Mammogram previous 2 yrs	56.5%	56.5%		73.2%	73.2%
PAP Tests	74.2%	74.2%		72.9%	72.9%

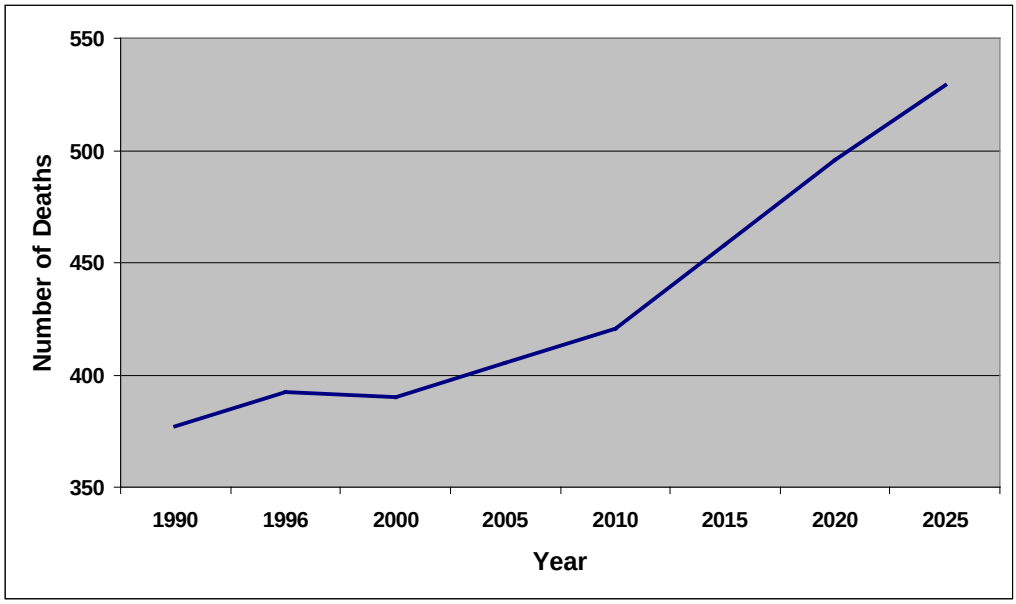
Source: THU Health Profile, Statistics Canada 2013

4.6 Mortality

Life expectancy at birth for local residents is 77.0 years - almost three years less than the 79.7 years that the average Ontario newborn can expect to be alive.

Approximately 425 residents die each year in Timiskaming District from all causes. Over the next ten years, the increase in the number of District residents over the age of 64, coupled with the District's higher than average death rate will have a dramatic impact on the number of people who are expected to die annually within Timiskaming District. During this decade, the number of deaths each year will rise by roughly 20%, to 500 per year. (Source: Coordinating End of Life Services for the District of Timiskaming, CCAC Timiskaming CASC, 2005) At the local level, this translates into an increase from 100 to 125 deaths annually.

Figure 9: Projected Number of Deaths in Timiskaming District, by Year (Five Year Intervals, 1990 to 2025)



Source: Coordinating End of Life Services for the District of Timiskaming, CCAC Timiskaming CASC, 2005

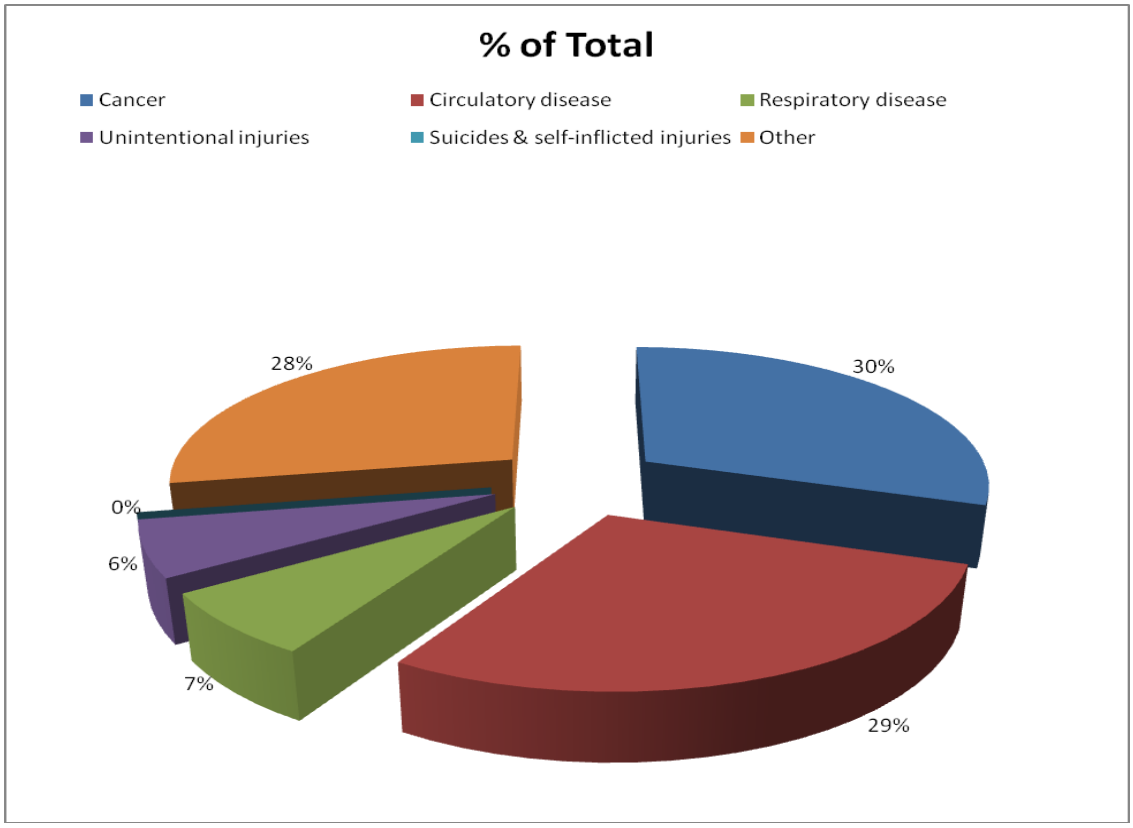
4.6.1 Causes of Death

The June 2010 Statistics Canada Health Profile for the Timiskaming Health Unit population provides much useful information in relation to death rates and causes of death, as illustrated in the table below.

The rate of death for local residents is 24% higher than the Ontario average, even when standardized for differences in the relative ages of the two populations. This is a reduction of 11% from 2010 levels. The following chart shows different causes of death as a percentage of the total death rate.

	Tim HU	Tim HU		Ontario	Ontario
Deaths	2010	2013		2010	2013
Total Death Rate, age standardized (per 100,000)	**764.4**	**646.8**		**597.8**	**521.8**
All Cancers	**237.9**	**194.8**		**176.2**	**159.1**
Colorectal Cancer	16.6	18.1		18.4	17.0
Lung Cancer	77.6	58.7		43.8	40.3
Breast Cancer	n/a	11.6		n/a	12.0
Prostate Cancer	n/a	9.1		n/a	8.0
Circulatory diseases	**243.2**	**184.5**		**205.0**	**155.6**
ischemic heart diseases	144.8	101.2		118.3	86.9
Cerebrovascular diseases	50.2	29.7		43.6	30.7
All other circulatory diseases	48.2	53.6		43.0	38.0
Respiratory disease	**58.5**	**46.6**		**44.6**	**41.3**
pneumonia and influenza	13.5	n/a		12.9	11.2
Bronchitis, emphysema and asthma	4.2	n/a		3.1	2.2
All other respiratory diseases	40.8	37.9		28.5	27.8
Unintentional injuries	**47.1**	**41.2**		**22.3**	**23.4**
Suicides and self-inflicted injuries	**11.6**	**0**		**7.7**	**7.7**
Human Immunodeficiency virus (HIV) diease	**0**	**0**		**1.2**	**0.9**

Source: THU Health Profile on Statistics Canada 2013



	Tim HU	Tim HU		Ontario	Ontario
Percentage Cause to Total Deaths	**2010**	**2013**		**2010**	**2013**
Cancer	31.8%	30.1%		29.5%	30.5%
Circulatory	31.8%	28.5%		34.3%	29.8%
Respiratory	7.7%	7.2%		7.5%	7.9%
Unintentional	6.2%	6.4%		3.7%	4.5%
Suicides	1.5%	0.0%		1.3%	1.5%
HIV	0.00%	0.0%		0.2%	0.2%

Circulatory Disease

Deaths due to cancer and circulatory diseases continue to account for more than half of all deaths.
Between 1990 and 1999, circulatory diseases accounted for 35-40% of all deaths in Timiskaming District. Current data shows a continuing declining trend, down to 29% of total deaths, which is comparable to the Ontario rate of 30%.

Cancer

During the decade from 1990 to approximately 1999, cancer accounted for approximately 25% of all deaths within the District, with nine of ten of these deaths occurring in people aged 55+ years. Presently, cancer accounts for one in three deaths locally, and roughly the same rate as the rest of Ontario. Unlike the remainder of the Province, Timiskaming cancer deaths actually declined by approximately 5%.

Respiratory Disease, Injury and Suicide

Deaths due to respiratory disease, unintentional injury, suicide and self-inflicted injury collectively account for 14% of all deaths locally, the same rate as provincially.

The local rate of death due to unintentional injury is more than the Ontario average.

4.7 Morbidity and Chronic Conditions

4.7.1 Access to Family Physician

The establishment of Family Health Teams within Timiskaming District has made a significant impact on access to physicians by local residents. The percentage of local residents who reported having no contact with a medical doctor had decreased in 2010 to be below the

provincial average however this number has increased in the past 3 years and is now slightly above the provincial number. The difficulty in attracting and retaining physicians in small, rural and Northern communities has a significant impact on physician access.

Figure 12: Percentage of Timiskaming District Residents Who Have Had No Contact with a Medical Doctor during the Past Twelve Months

		Tim Dist.	Ontario
2013	**Total**	**18.6%**	**17.8%**
	Male	21.0%	22.6%
	Female	16.2%	13.1%
2010	**Total**	**12.2%**	**17.1%**
	Male	11.0%	21.9%
	Female	13.1%	12.5%
2003	**Total**	**28.9%**	**18.3%**
	Male	39.35	23.7%
	Female	18.8%	13.0%
2000/2001	**Total**	**26.8%**	**16.8%**
	Male	34.3%	22.0%
	Female	19.7%	11.7%

Source: THU Health Profile Statistic Canada 2013

The Englehart and District Family Health Team is funded for six salaried physicians however the Family Health Team is rarely able to fill all six positions for any significant duration. These physicians, and the other clinical service providers associated with the Team, are responsible for meeting the primary health needs of the residents of Central Timiskaming.

4.7.2 Chronic Disease

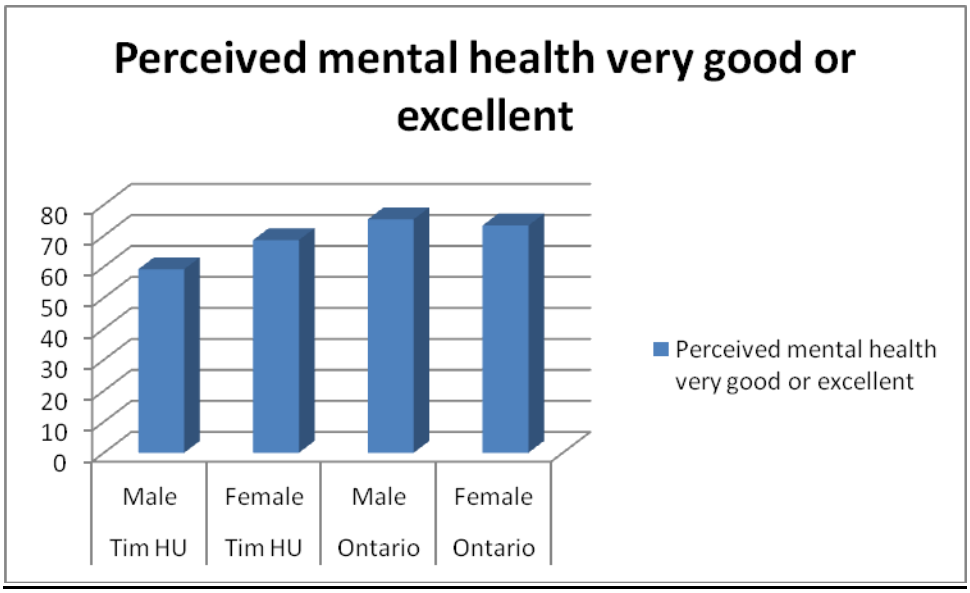
Local residents report significantly higher instances of chronic obstructive pulmonary disease, arthritis and rheumatism, asthma, and high blood pressure than Ontarians overall, however there is no difference between the instances of diabetes.

Figure 13: Percentage of Timiskaming District Residents with Select Chronic Conditions

	Tim District	Ontario	Difference
Diabetes	6.8%	6.8%	0.0%
Arthritis and Rheumatism	23.1%	17.3%	33.5%
Asthma	9.4%	8.3%	13.3%
High Blood Pressure	27.0%	17.4%	55.2%
COPD	13.8%	4.2%	228.6%
CHF	n/a	n/a	n/a
Dementia	n/a	n/a	n/a
Source: THU Health Profile, Statistics Canada 2013			

4.7.3 Mental Health

On average, three of every four Ontarians rate their mental health to be very good to excellent, with little difference between male and female populations overall. Self-assessments by local residents are not as positive. Within the District, only two of three residents rate their mental health as very good to excellent. As with the perception of overall health status, there is significant variance between the genders, with 59% of men and 68 % of women identifying very good to excellent mental health. (THU Area Health Profile, January 2013)



4.8 Other Health Service Providers

A variety of organizations provide health services locally to the residents of Central Timiskaming, including: the health unit, community care access centre, mental health services, diabetes support services and televideoconference links with medical specialists.

Obstetrical services, general surgical services, and chemotherapy support are available in community hospitals located 50 kilometres distance. For more specialized medical or hospital based services, residents must travel to reach nearest secondary referral centres in North Bay (200 kms distance), Timmins (170 kms distance), Sudbury (260 kms distance), and Toronto 530 kms distance). Peadiatric services are generally referred to Ottawa (1,124 kms distance).

A list of the key primary health care providers and services available to catchment area residents is included below, with a description of their services following:

- Canadian Mental Health Association
- Centre de Santé Communautaire du Timiskaming
- Community Care Access Centre
- District of Timiskaming Social Services Administration Board

- Englehart and District Family Health Team
- Englehart and District Physician Services
- Foot Care Clinic
- Kirkland and District Hospital
- Northeastern Ontario Infection Control Network
- Northern Radiology PACS Project
- Northview Nursing Home
- Timiskaming Hospital
- Timiskaming Addictions and Mental Health Services
- Timiskaming Diabetes Program
- Timiskaming Health Unit
- Timiskaming Home Support
- Timiskaming Palliative Care Network
- University Health Network Laboratory Medicine Program
- Well Women's Clinic

In conjunction with the Timiskaming Health Unit, the Cochrane Timiskaming branch of the **Canadian Mental Health Association** provides mental health services for the residents of Timiskaming District out of two offices. The range of services available includes:

- An Assertive Community Treatment (ACT Team)
- Community outreach and support, including specialized support for people with dual diagnosis of mental health disorders and developmental disorders
- Court support
- Crisis response team and information referral
- Housing spaces and supports
- Public education to: increase understanding and acceptance of mental illness, reduce stigma associated with mental illness, increase awareness and prevention of family violence, and promote the development and maintenance of good mental health
- Northern Star Consumer/Survivor and Family Network, and support groups
- Skills development and psycho-social rehabilitation, and
- A regionally based Women's Shelter, including a Child Support Program.

The **Centre de Santé Communautaire du Timiskaming** (CSCT) provides primary care services for Timiskaming District residents who wish to receive service in French. There are a number of CSCT locations distributed throughout the District. Service providers associated with this primary health team include physicians and nurses.

The **Community Care Access Centre** (CCAC) serves local residents from a branch office in Kirkland Lake, with a satellite site in Englehart. This organization:

- Provides information about community health services
- Make referrals to other community services
- Provides health care services in homes and schools either directly or by contracting with other agencies

- Manages admissions to long-term care facilities and adult day program, and
- Provides certain medical supplies and equipment to clients in their homes.

The District of Timiskaming Social Services Administration Board (DTSSAB) is responsible for providing a number of services for District residents, including:

- Ontario Works - financial and employment assistance to people in temporary financial need
- Best Start and Child Care Services - funding, negotiating service contracts, subsidy management
- Land Ambulance Services - sole provider of emergency medical transportation services for the District
- Social Housing - direct management of the public housing portfolio, the administration and maintenance of the Central Waiting List, and the administration of the social housing programs within the District.

The **Englehart and District Family Health Team** (EDFHT) was initially funded in 2007, to provide comprehensive primary health care service to the residents of Central Timiskaming District. The EDFHT complements physician services with additional clinical professionals including: two Nurse Practitioners, fulltime and part time Registered Nurses, a Pharmacist, a Dietitian, and Social Worker. The Family Health Team operates out of the Englehart Medical Centre, located adjacent to the Englehart and District Hospital.

Englehart and District Physician Services (EDPS) is a Rural Northern Physician Group which serves the needs of the residents of Central Timiskaming for primary care family medicine. Members of the EDPS are affiliated with the EDFHT and have their offices in the Englehart Medical Centre. A pharmacy and dentist's office is located in this building as well. One of the physicians in this group practice is affiliated with the Northern Ontario School of Medicine, mentoring second year medical students in local clinical clerk placements. The physician members of this group currently provide services on site to residents of the Northview Nursing Home, and staff the Elk Lake Nursing Station.

The **Foot Care Clinic** is sponsored by Englehart and District Hospital but is operated separately from the hospital. It is staffed by Registered Nurses on a rotational basis, providing services one day each week. Referrals to the Foot Care Clinic are made by individuals, family physicians, and the Timiskaming Diabetes Program. Clients of the Foot Care Clinic pay a fee for each visit, with the local Lions Club donating funds toward the cost of the clinic for diabetic patients.

Kirkland and District Hospital provides a variety of programs and services, some of which are not available at Englehart and District Hospital. The following services are particularly of interest to local residents: community asthma clinic, dialysis, intensive care unit, oncology services, physician specialist clinics, surgical services, and the Ontario Breast Screening Program.

The **Northeastern Ontario Infection Control Network** (NEOICN) is responsible for coordinating infection prevention and control activities and promoting standardization in healthcare facilities across the region.

The **Northern Radiation (NORRad) PACS Project** uses proven health care and communications technology to provide the support of radiologists in interpreting digitized x-rays. Digital images are transported electronically from the local site, where the image is captured, to the remote radiologist, who analyzes the digital image and reports his or her findings to the local family physician.

Northview Nursing Home provides long term care accommodation for the residents of Central Timiskaming. This facility is currently classed as a level "C" facility and will not be able to meet the future physical standards for long term care facilities

Temiskaming Hospital also provides a range of hospital-based services not available at Englehart and District Hospital that local residents make use of. These include: Diagnostic Imaging procedures (CAT scan and mammography), dialysis, special care unit, oncology services, physician specialist clinics, birthing and maternal child health services, and surgical services.

The **Timiskaming Diabetes Program** (TDP) is one of 39 programs included under the umbrella of the Northern Diabetes Health Network. The TDP is staffed by dietitians and nurses who are Certified Diabetes Educators and provides diabetes education and care for people living with diabetes. In addition to appointments for those living with diabetes, the program also organizes and hosts many workshops and events to promote healthy living and self-management of diabetes, as well as workshops for local physicians and other healthcare professionals to obtain the latest information on diabetes care.

In response to the health needs of the community, the **Timiskaming Health Unit**:

- Provides health education, public education, public awareness campaigns and skill building opportunities.
- Advocates for public policy that supports good health such as healthy eating, active living and not smoking
- Responds to natural and man-made environmental emergencies
- Monitors the health status of the community
- Provides clinical services, and
- Partners with individuals, groups and agencies to provide optimum services

Timiskaming Home Support provides a number of non-clinical services designed to assist people to remain in their own homes for as long as possible. These services include: accessible transportation, adult day service, attendant outreach, collective kitchen, diners' club, friendly home visiting, home help, home maintenance, meals on wheels, emergency response, supportive housing, and telephone reassurance.

The **Timiskaming Palliative Care Network** is a volunteer focused organization, whose mission is to support individuals diagnosed with a life-threatening illness, their families and loved ones, and provide a coordinated community-based supportive care program while working in conjunction with all team members. Their primary services include providing supportive care, pain and symptom management, and education.

The **University Health Network Laboratory Medicine Program** includes 400 staff members who provide advanced, high quality laboratory services. This includes performance of laboratory tests that are not included in local test menus, as well as providing the skills of expert physicians who serve as the Medical Director for the hospital's Laboratory

The **Well Women's Clinic** (WWC) is a collaborative effort of the Englehart and District Family Health Team and select physicians working in Englehart and District Physician Services. Prior to the existence of the EDFHT, this service was provided by the hospital. The clinic performs breast exams, teaches breast self-examination, and performs PAP tests. Educational services are also provided, focusing on menopause, hormone replacement therapy and osteoporosis. Information is provided regarding natural bodily changes and processes over a woman's lifetime. Services are available to women of all ages in the District of Timiskaming.

4.9 Labour Markets

Englehart and District Hospital employs nurses, allied health professionals, administrative staff, and support services staff.

Support staff and clerical staff are typically recruited from the local population. Nurses and allied health professionals are recruited locally, as well as provincially. Colleges and universities that graduate nurses and allied health professionals are key sources of employees for hospitals. Senior administrative staff may be recruited locally or provincially, while managers are usually found within the local population.

The Markets for skilled positions have reduced recently due to lay offs at larger health centers. Although competition for the resources is still stiff there is a noticed improvement in the ability to attract some staff positions, notably nursing. Laboratory and Diagnostic Imaging technicians continue to be an exception to this principle. Shortages in these areas continue and can have a significant impact on hospital resources and patient service times.

5.0 INTERNAL ENVIRONMENT

5.1 Mission, Vision and Values

As part of the strategic planning process, the Board of Directors of Englehart and District Hospital considered its established statements of mission, vision and values, to determine if they should be revised.

The existing mission, vision and value statements formed a solid foundation for decision making and for guiding actions. However, the strategic planning working group decided these statements required a refresh to reflect current concepts. The resulting mission, and vision statements reflect a focus on "Quality health care" as a more encompassing concept. In addition, these statements were updated to focus on an all inclusive phrase, "the entire health care team".

The value statements were updated by reprioritizing our values to better align with our cultural beliefs. For example, patient centered care was moved to the top priority and combines within it the wording from the Compassionate, Ethical, Quality Care value.

The mission statement succinctly defines what it is that the organization does. The statement of vision tells everyone where the organization intends to go. The statement of values influences the choices that the organization makes in deciding which paths to follow in order to reach its vision and in working day by day.

It is our **mission** to serve the residents of Central Timiskaming by:

- Providing the best Quality health care
- Ensuring seamless transitions to other health services
- Collaborating with other community partners to create a safe and healthy community, and
- Creating an environment where the entire health care team can do their very best work

It is our **vision** to be:

- A leader in Quality health care services.
- A collaborative workplace for the entire health care team.
- An innovative and valued partner in our community, respected by our peers.

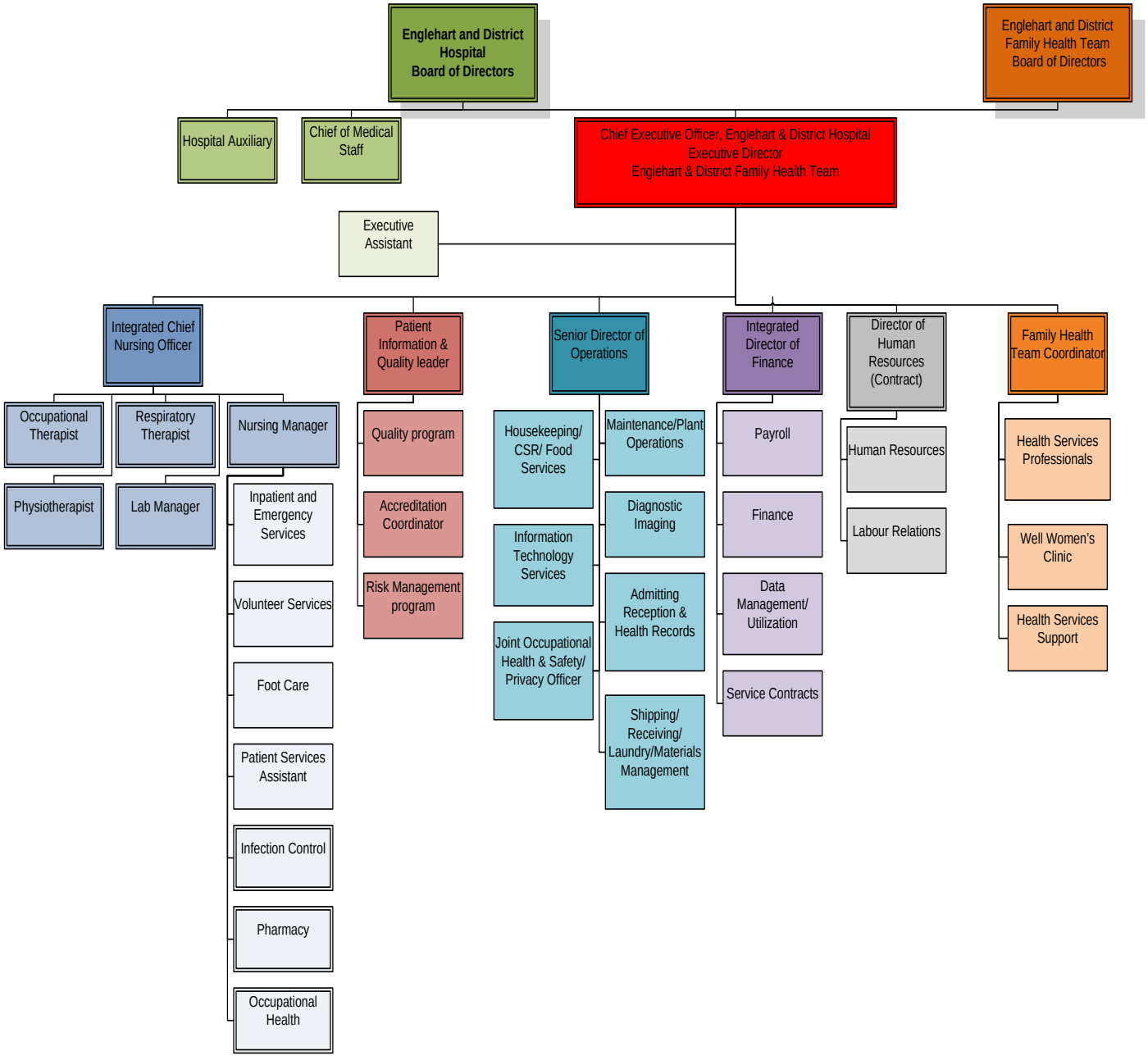
We have chosen the following **values** to reflect what is important to us:

- **Patient Centred Care**
  We provide compassionate and ethical quality care using systems and processes that consider the best interests of the patient, delivered by people who put the patient first. "We treat every patient as if they were family".
- **Integrity**
  We conduct ourselves with the highest standards of professionalism, honesty, and fairness in everything we do.

- **Innovative Leadership**
  We continually seek new and creative ways of doing things. In addition to adopting quality practices where they exist, we will create new ones where they do not.
- **Commitment to Integration**
  We recognize that we can achieve far greater things on behalf of local residents, by working in collaboration with other agencies and individuals, than we can do in working alone
- **Community Focus**
  We focus our energy and resources on those health issues and services that matter most to our families, neighbours, and community members.
- **Accountability**
  We are accountable to our patients, our community, and our government to deliver the highest quality care in a fiscally responsible manner.

In order to achieve its mission and vision, EDH has chosen the organizational structure shown on the following page.

Figure 14: Organizational Chart



5.2 Physician Services

5.2.1 Family Physicians

The family physicians that provide service to the residents of Central Timiskaming are compensated through a Rural and Northern Physician Group Agreement (RNPGA) funding arrangement with the Ministry. This contract provides spaces for six physicians to serve the community. These physicians are affiliated with the Englehart and District Family Health Team, as well as the Englehart and District Hospital. In addition to providing clinic appointments the group is responsible for attending to all inpatients and providing coverage for the emergency room, supported by specific ancillary Ministry funding agreements.

While there are places for six physicians through the RNPGA, the number of physicians who actually support the community at any given time varies widely, ranging from six to three over a four year time span. Physician recruitment and retention continues to be a major organizational challenge that requires significant time, effort and resources to address. This requirement will be an ongoing item.

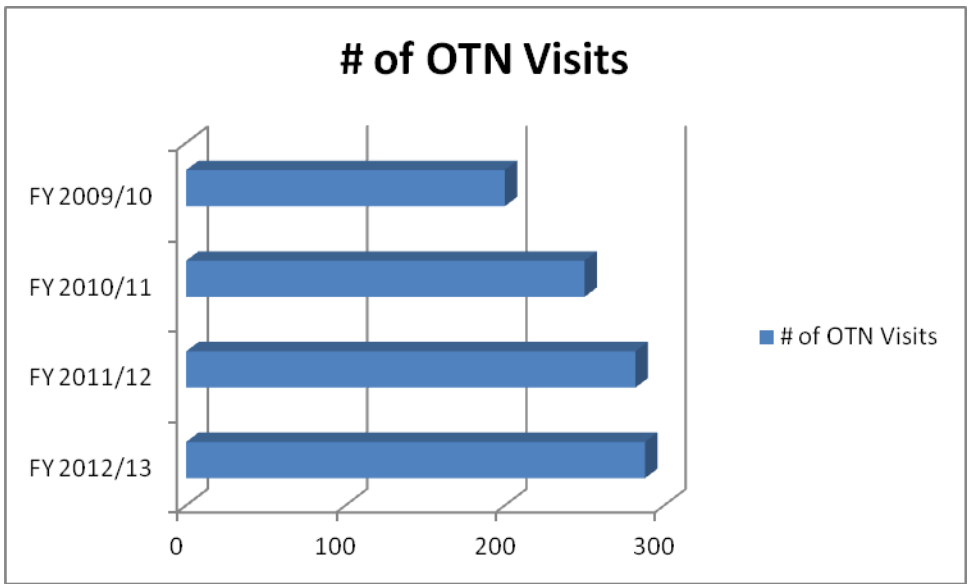
5.2.2 Physician Specialists

Physicians specializing in psychiatry, gynecology and neurology currently visit local residents by attending onsite at Englehart and District Hospital.

Residents of the area are typically referred to other communities for specialist services as follows:

- Routine obstetrical services are provided by New Liskeard
- Complex obstetrical services are provided by Timmins
- General surgical services are provided by New Liskeard and Kirkland Lake
- Cardiology, cardiovascular surgery and neurosurgery services are provided by Sudbury
- Pediatric services are provided by North Bay and Ottawa
- Internist and orthopedic surgery services are provided by all of North Bay, Sudbury and Timmins
- Urology services are provided by North Bay, Toronto, Sudbury and Timmins

Englehart and District Hospital also provides the services of physician specialists to local residents by hosting an Ontario Telehealth Network televideoconferencing site. This service has been in operation since 2003 and the number of patients using this service is steadily increasing each year as illustrated in the graph on the following page.



5.3 Acute Inpatient Cases

Englehart and District Hospital operates sixteen acute care beds and has maintained this complement over the past 11 years.
Occupancy of acute beds has ranged from 38-113% of the acute inpatient beds available over the past five years, trending upward throughout the period. It has been possible for the hospital to achieve greater than 100% occupancy since 2009 as a result of vacant complex continuing care beds.

Figure 15: Acute Inpatient Occupancy Summary, by Year

	2010/2011			2011/2012			2012/2013		
	EDH	KDH	TH	EDH	KDH	TH	EDH	KDH	TH
Patient Days	5,970	13,891	16,071	6,403	13,685	15,970	7,367	11,667	16,691
Average LOS	18.3	10.3	7.9	14.6	10.2	8.1	20.4	9.1	7.4
Discharge	326	1,347	1,925	438	1,342	1,933	362	1,281	2,009
Occ. Rate	48%	81%	92%	54%	80%	91%	66%	68%	95%
Total W/C	723.3	1,977.1	2,673.0	na	na	na	na	na	na

Note: The Statistics for Acute Care for TH includes: SCU, OBS, M/S for a total of 48 beds.
Note: The Statistics for Acute Care for KDH is based on 47 Acute care beds

The Ministry calculates the cost of providing service in terms of a metric called Cost per Equivalent Weighted Case (CEWC). This involves several steps:

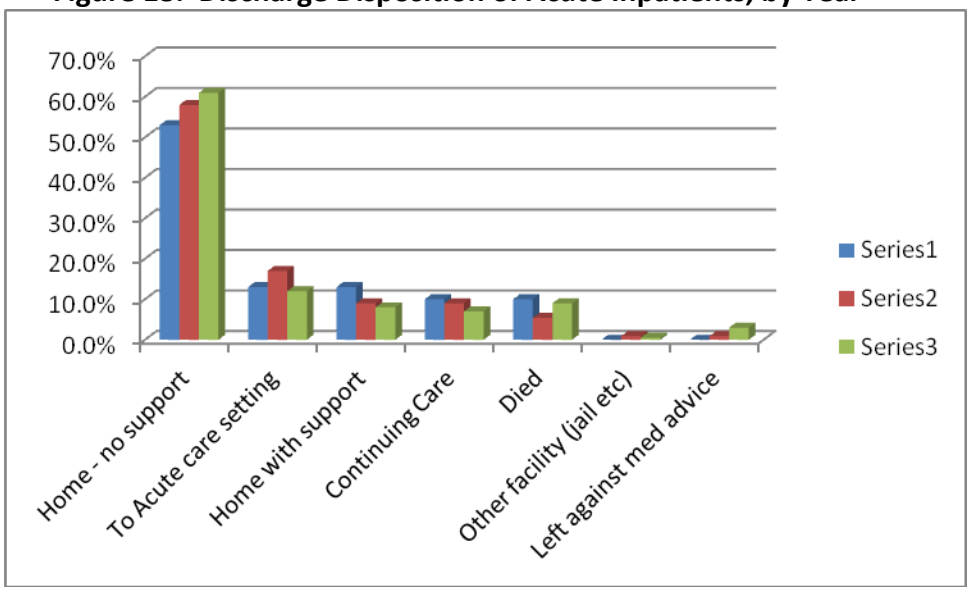
- Translating the number and complexity of the acute cases, complex continuing care cases and emergency room visits into 'equivalent weighted cases'
- Establishing an expected cost per equivalent weighted case (ECEWC), and

- Comparing the hospital's actual cost per equivalent weighted case (ACEWC) to the ECEWC

More than 60% of the hospital's inpatients are discharged home with no support required. Another 8% are currently discharged home but with support services in place, which represents a declining proportion of discharged patients over the past three years, and results from lack of availability of services to patients in their homes.

12% of Englehart and District Hospital's inpatients have been discharged to receive services at another acute care facility.

Figure 18: Discharge Disposition of Acute Inpatients, by Year



Blue – 2010, Red is 2011, Green is 2012

Other performance measures for Acute Services typically result from third party evaluation, comparative assessments against the performance of other hospitals, and patient satisfaction data.

Englehart and District Hospital measures its performance against the Accreditation Canada Acute Services standards. During the most recent site survey, in June 2012, surveyors determined that nine (9) of the required organizational practices (ROPs) had not been met. (Required Organizational Practices are essential practices that all organizations must have in place to enhance patient safety and minimize risk.) Unmet ROPs included:

- Establishing a list of abbreviations, symbols, and dose designations not to be used in the organization
- Verifying identity with two client identifiers
- Infusion pump training
- Ensuring Information transfer among service providers at transition points

These issues were subsequently addressed and by May 2013 with an additional enquiry completed in November 2013. Therefore by November 2013 the hospital was compliant with all of the Accreditation Canada standards that apply to Acute Services.

A new patient satisfaction survey was developed in 2012 for both Emergency Room and Inpatient services. The results for 2012 and to date in 2013 are as follows.

	2012/13	2013/14
Emergency Room	90%	89%
Inpatients	99%	98%

5.4 Complex Continuing Care Inpatient Services

Englehart and District Hospital operates fourteen complex continuing care beds and has maintained this complement over the past 14 years.

There has been a declining trend in the occupancy of the hospital's complex continuing care beds over the past 6 years, as a result of changes in the criteria for patient admission to this service.

Figure 19: Complex Continuing Care Occupancy Summary, by Year

	Patient Days	Discharges	Occupancy Rate %
FY2012/13	299	1	5.9
FY2011/12	961	3	25.7
FY2010/11	1124	3	47.7

Source: Quality leader EDH

Both Kirkland and District Hospital, and Temiskaming Hospital also provide complex continuing care for residents in their catchment areas, allocating fifteen beds and eleven beds respectively for this level of care. There are a total of forty complex continuing care beds throughout the District.

Due to the increased restrictions on the type of patients who qualify for Complex Continuing Care beds, it is anticipated that few, if any, will qualify in the future. As a result, these beds are being used to care for Alternate Level of Care patients.

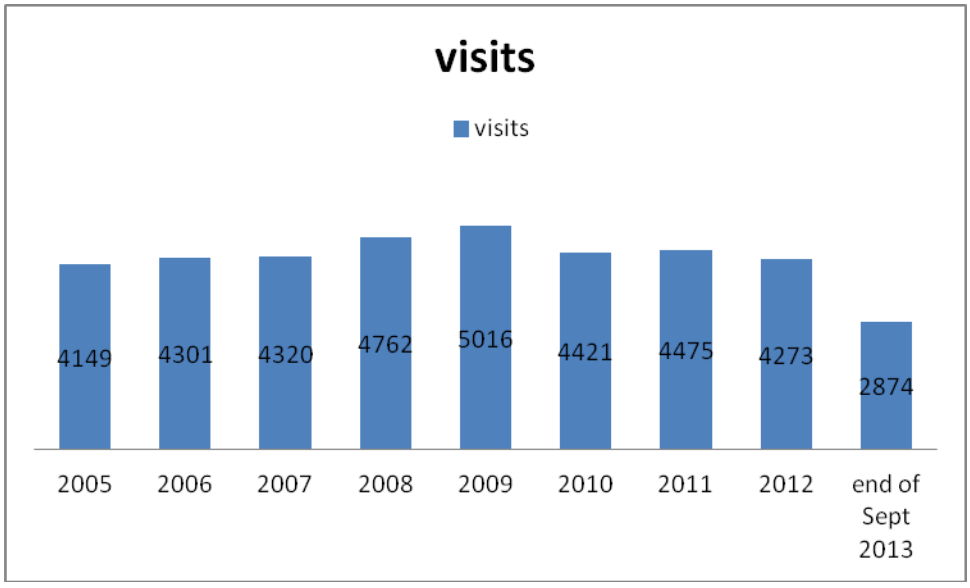
Englehart and District Hospital measures its performance against the Accreditation Canada Long Term Care standards.

5.5 Emergency Services

The emergency department provides services for outpatients who arrive on both a scheduled and unscheduled basis.

On average, 14 patients used Emergency Services daily in 2009. In 2012 this number declined to 12 patients per day. Over the three year period from 2002 to 2005, there was a gradual but substantial 20% decline in the number of visits to the hospital's emergency department visits. However, from 2005 to 2009 the demand for emergency services increased by the same 20%, returning to the same level that existed twelve years ago. The changes in Emergency Services volumes relate to the complement of physicians available to see patients in their office and through the walk in clinic at the Medical Clinic. The period from 2004 to 2007 reflects a period of time when there was a full complement of six physicians, decreasing use of the hospital's Emergency Services. For the perios from 2009 to 2012, the physician complement fluctuated between 4 and 6 physicians, resulting in a 14% decrease in patient visits. In late 2013 the physician complement dropped to 3 for a period with an increased utilization of Locum physicians which is expected to increase patient volumes.

Figure 20: Number of Emergency Services Visits, by Year



The performance of Emergency Services is typically measured by overall patient waiting time, and by compliance with national standards that relate to the amount of time elapsed from patient arrival to nurse triage, and the amount of time elapsed from patient arrival to physician assessment. 100% of patients were triaged by a nurse within fifteen minutes of their arrival.

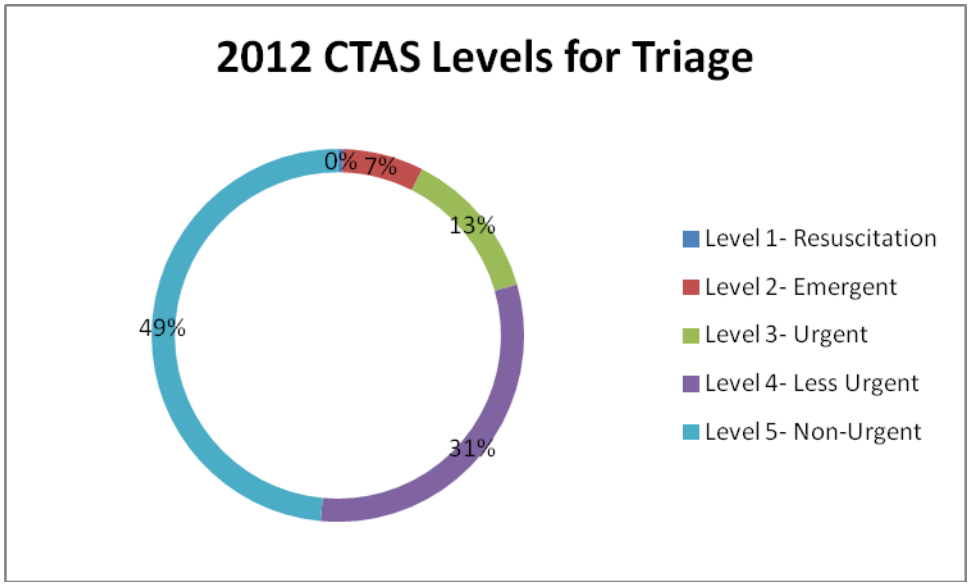
Visits to Emergency Services throughout Ontario are triaged using the Canadian Triage and Acuity Scale (CTAS). This scale assesses the relative urgency of the reason for visit, and provides guidelines to indicate the maximum recommended elapsed time prior to assessment of the

patient by a physician. Individuals whose visits are assigned to Triage Code 1 require services on the most urgent basis, while those assigned to Triage Code 5 needs services least urgently.

Since 2009 as Emergency Services visits follow the same pattern, with roughly 76% of patients assessed as being less urgent or non-urgent, able to wait one or two hours before seeing a physician, according to the CTAS guidelines. This is down from 84% in 2009. Over 7 percent of patients visiting the Emergency Room (six each week) need services on an emergent basis, meaning that a physician should be tending to them within fifteen minutes of their arrival at the emergency department. And another 13% of patients (more than 1 each day) need services urgently, meaning that a physician should assess them within thirty minutes of their arrival. The four year trend is that patients presenting in the Emergency room are more ill then in the past and are more complex as they tend to present with co morbidities.

CTAS Level	2009	2010	2011	2012
Level 1- Resuscitation	0.00%	0.68%	0.60%	0.44%
Level 2- Emergent	4.00%	5.18%	5.50%	6.76%
Level 3- Urgent	12.00%	11.51%	12.51%	12.61%
Level 4- Less Urgent	44.00%	35.15%	31.82%	29.74%
Level 5- Non-Urgent	40.00%	41.21%	44.25%	46.71%

Source: Registration at EDH



The overall length of stay of the patients in the Emergency room averaged 110 minutes during 2009 and has increased to 151 minutes, due to the increased acuity

Figure 22: Length of Stay in Emergency Room, by Year

Year	Total Emerg Visits	Average Length of Stay	Less than 1 hour	1-3 hours	3-12 hours	12-24 hours	Holding > 24 hours and other
2010	4,421	137 minutes	50%- 32 min	37% 101 min	9%- 324 min	3%- 1,063 min	1%- 1,940 min
2011	4,475	135 minutes	42%- 32 min	42% 104 min	13%- 325 min	3%- 1,086 min	0%- (16 cases)-1,673 min
2012	4,273	151 minutes	43%- 39 min	40% 103 min	13% - 329	4%- 1,090 min	1%- 1,647 min

Source: Quality Leader

Emergency visits are coded and abstracted by the staff in Health Records. For ease of comparison, similar kinds of emergency room visits are grouped together, using a grouping methodology called the Comprehensive Ambulatory Care System (CACS). Since 2003, the Ministry has provided hospitals with comparative, summary information, based on visit data submitted by hospitals. The table included below highlights the five CACS groups that account for a significant portion of the hospital's emergency visits.

Figure 23: Top Five Emergency Room CACS, by Year

Most Responsible Diagnosis			
	2010/11	2011/12	2012/13
1	Other chemotherapy	other chemotherapy	other chemotherapy
2	dressings and sutures	unspecified abd pain	Other unsp. Med care
3	other medical care	Urinary tract inf.	unspecified abd pain
4	Acute Resp. Inf.	Unspecified abd. Pain	urinary tract inf.
5	Urinary tract Inf.	other medical care	surgical dressings

Source: Quality leader

Notes: 'Other chemotherapy' refers to antibiotic intravenous medication.

In 2008 the emergency department was reconfigured to provide more privacy for patients and to reduce the risk of spreading infection and to ensure the confidentiality of personal health information.

5.6 Nursing Services

As of March 2013, Nursing Services were provided by Seventeen Registered Nurses and fifteen Registered Practical Nurses. The number and skill mix of the nursing staff is provided in the following table.

Figure 24: Nursing Skill Mix, March 2010

Year	Number	FT	PT	CPT	Total
2013	RN's	7	5	5	17
	RPN's	4	7	4	15
	PSW's	0	5	0	5
	Total	**11**	**17**	**9**	**37**
2012	RN's	11	2	5	18
	RPN's	5	8	7	20
	PSW's	0	5	0	5
	Total	**16**	**15**	**12**	**43**
2011	RN's	11	2	2	15
	RPN's	5	8	4	17
	PSW's	0	4	0	4
	Total	**16**	**14**	**6**	**36**
2010	RN's	10	2	2	14
	RPN's	5	5	6	16
	PSW's	0	4	0	4
	Total	**15**	**11**	**8**	**34**

Source: EDH Finance Dept.

Registered Nurses work in Acute Inpatient Services, Complex Continuing Care, Emergency Services, the Well Women's Clinic, and the Foot Care Clinic. Registered Practical Nurses work in all areas except the Well Women's Clinic.

In order to work at Englehart and District Hospital, Registered Nurses must be registered with the College of Nurses of Ontario, and hold current certification in: CPR, Advanced Cardiac Life Support, Trauma Nursing Core Course, and phlebotomy skills. Registered Practical Nurses must be registered with the College of Nurses of Ontario and hold current certification in: CPR, physical assessment, medication administration, and phlebotomy skills. There is a very active program of ongoing education for nursing staff at Englehart and District Hospital. In 2013, the Hospital completed a training program to bring the Registered Practical Nurses skills to the full extent of their scope of practice. This, in addition to relieving pressure on the Registered Nursing pool, is intended to be a retention initiative for Registered Practical Nurses by increasing job satisfaction.

The following table provides information comparing the number of hours of paid time reported for nursing staff of differing skills.

Figure 25: Paid Nursing Hours by Nursing Skill

Year	Hours	FT	PT	CPT	Total
2012-2013	RN's	17,814	5,140	307	23,261
	RPN's	9,818	5,675	1,997	17,490
	PSW's	0	3,673	1,456	5,129
	Students	0	269	0	269
	Total	**27,632**	**14,757**	**3,760**	**46,149**
2011-2012	RN's	20,324	2,333	850	23,507
	RPN's	11,661	6,995	1,881	20,537
	PSW's	0	3,629	1,566	5,195
	Students	0	465	0	465
	Total	**31,985**	**13,422**	**4,297**	**49,704**
2010-2011	RN's	19,973	2,145	463	22,581
	RPN's	9,800	4,824	1,716	16,340
	PSW's	0	4,416	665	5,081
	Students	0	521	0	521
	Total	**29,773**	**11,906**	**2,844**	**44,523**
2009-2010	RN's	15,032	3,312	934	19,278
	RPN's	10,353	5,260	2,532	18,145
	PSW's	0	4,260	458	5,078
	Students	0	2,252	0	2,252
	Total	**25,385**	**15,444**	**3,924**	**44,753**

Source: EDH Finance Department

Includes all hours/overtime/premium/vacation/sicktime

5.7 Diagnostic and Therapeutic Services

Diagnostic and Therapeutic Services are provided by employees of Englehart and District Hospital, as well as by staff who are retained on a contractual basis.

The hospital participates in two significant partnerships in relation to diagnostic services. Englehart and District Hospital is partnered with Lifelabs and the University Health Network to obtain support for Laboratory Services. In Diagnostic Imaging, the hospital partners with Timmins' based NORrad for radiologist support and PACS technology.

5.7.1 Diagnostic Imaging Services

The Diagnostic Imaging Services provided locally include Xray, Bone Mineral Density, Holter, Echo Cardiogram, Ultrasound and Echo/Doppler examinations. These services are provided by a full time working supervisor, a part time technologist and several part time and casual employees.

Figure 26: Diagnostic Imaging Service Volumes,

Exam Type	FY 2012/13 EXAMS				
	Acute	Out Pt	Total	Total W/L Units	Total hours
Xray	520	2,546	3,086	31,066	
Bone Mineral Density	3	99	102	1,520	
Holter	14	106	120	3,600	
ECG	414	876	1,290	21,930	
Ultrasound	173	535	708	17,930	
Echo/Doppler	22	140	162	7,975	5,110
	20.96%	78.68%	5,468	84,021	

Exam Type	FY 2011/12 EXAMS				
	Acute	Out Pt	Total	Total W/L Units	Total Hours
Xray	652	2,874	3,526	35,143	
Bone Mineral Density	2	91	93	1,395	
Holter	5	131	136	4,080	
ECG	588	966	1,554	26,418	
Ultrasound	120	435	573	18,385	
Echo/Doppler	20	124	144	7,095	5,049
	23.02%	76.68%	6,026	92,516	

Exam Type	FY 2012/13				
	Acute	Out Pt	Total	Total W/L Units	Total Hours
Xray	256	2,913	3,169	33,016	5920
Bone Mineral Density	5	108	113	1,630	
Holter	3	158	161	4,830	
ECG	393	1,108	1,501	52,217	
Ultrasound	162	714	876	23,145	
Echo/Doppler	22	125	147	6,405	
	14.09%	85.91%	5,967	121,243	

5.7.2 Laboratory Services

Figure 27: Laboratory Service Volumes

Lab Tests	Acute	Chronic	Out-pt	TOTAL	UPP worked	total hours	% of Out-pt
2012-2013	21,191	11	140,193	161,395	4,999	7,080	86.90%
2011-2012	24,103	1,120	114,223	139,446	5,359	7,103	81.90%
2010-2011	17,441	398	101,948	119,787	4,573	6,189	85.10%
2009-2010	11,530	640	74,382	86,552	6,525	6,525	85.90%

The Hospital laboratory is staffed by an Integrated Laboratory Supervisor (with Kirkland & District Hosptial) and two full time medical laboratory technicians and one part time phlebotomist.

There is a unique program of quality management for laboratory services, called QMP-LS, that is managed by the Ontario Medical Association. A major component of QMP-LS is Ontario Laboratory Accreditation (OLA). OLA was implemented in 2003, and supports local laboratories by providing: standards of practice guidelines, a peer-group accreditation program, and support for utilization management.

In accordance with the OLA process, Englehart and District Hospital has submitted several self-assessments, measuring its own conformance with the OLA standards. The Laboratory's

performance is reviewed every 3 years and was reviewed by external surveyors in 2012. The results of the self-assessments and peer review are summarized in the table included below. The organization's goal of achieving full conformance with the OLA standards has been achieved.

Figure 28: Conformance with OLA Standards, by Year

	2008 (Self)			2010(self)			2013 (Peer)	
	No.	%		No	%		No.	%
Standards met	477	97.3		477	97.3		426	91.8
Major non-conformance	1	0.2		1	0.2		13	2.8
Minor non-conformance	12	2.4		12	2.4		25	5.4
Total	490			490			464	

5.7.3 Therapy Services

Therapy Services are provided for each discipline by one full-time employee and staff, or by part-time contracted staff.

- Physiotherapy is provided by one full-time Physiotherapist, and one full-time Physiotherapy Assistant.
- Occupational Therapy is provided by one part-time Occupational Therapist, on a contractual basis.
- Respiratory Therapy is also provided by one part-time Respiratory Therapist, on a contractual basis.

Figure 29: Therapy Visits, by Service and Patient Type

	2012					
	Acute	CCC	Out	ALC	Total	Hours
Occupational Therapy	210	4	185	0	399	645
Physiotherapy (see note)	938	31	1,332	489	2,790	3,900
Respiratory Therapy						
	2011					
	Acute	CCC	Out	ALC	Total	Hours
Occupational Therapy	179	30	253	0	462	705
Physiotherapy (see note)	787	272	1,400	563	3,022	3,900
Respiratory Therapy						
	2010					
	Acute	CCC	Out	ALC	Total	Hours
Occupational Therapy	219	49	159	0	427	690
Physiotherapy (see note)	889	192	919	427	2,427	3,900
Respiratory Therapy						

Note: Physiotherapy- Inpatient acute visits are projected to continue to rise due to newly announced initiative for the Senior Friendly Hospital Improvement Plan which when implemented will demand a physiotherapy assessment and care plan development for every inpatient over 65 years of age. This is the predominant demographic at EDH and thus will frequently mean an assessment on all patients in the hospital.

Trends- 1. Inpatient visits overall rising
2. Acute inpatients visits rising
3. CCC inpatients dropping
4. ALC visits steady
5. Outpatient visits- rising

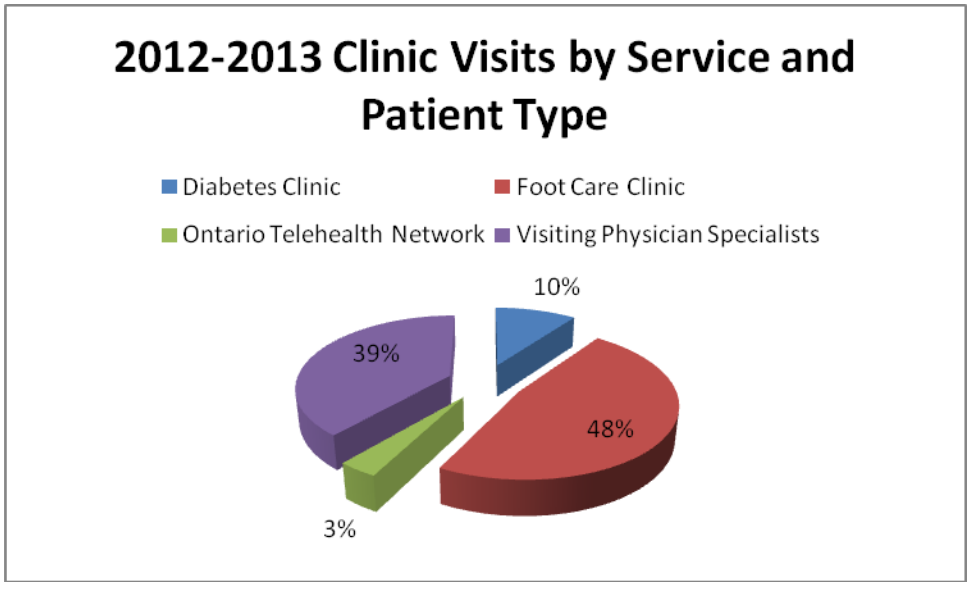
5.8 Clinic Services

Englehart and District Hospital operates a number of clinics, including a Foot Care Clinic, Visiting Physician Specialist Clinics, the Diabetes Clinic, and Telehealth services.

The Well Women's Clinic previously operated by the hospital has now transitioned to the Englehart and District Family Health Team.

Figure 30: Clinic Visits, by Service and Patient Type

	2009-2010	2010-2011	2011-2012	2012-2013
Diabetes Clinic	842	246	200	240
Foot Care Clinic	821	1,000	1,055	1,138
Ontario Telehealth Network	206	39	41	85
Visiting Physician Specialists	293	624	793	926



5.9 Administrative and Support Services

For the purpose of this document, Administrative Services includes: General Administration, Finance, Human Resources, Employee Health, Information Services, and Materials Management. Support Services includes: Maintenance, Registration, Health Records, Food Services and Housekeeping.

Administrative and support staff account for slightly more than one-third of the employees of Englehart and District Hospital. Of these, four full-time equivalent staff are management and clerical support personnel, while the remainder are considered by the Ministry to be 'unit producing personnel', directly involved with providing patient care or support services, such as cleaning rooms, making food, and maintaining the building.

It is important to note that there are several indicators of positive performance in the metrics provided in the following table. These include that:

- The number of Management and Other Support FTEs has decreased over the past five years, both in real terms and as a percentage of the overall employee population
- Conversely, this means that the proportion of staff who are classified unit producing personnel has increased
- The percentage of unit producing personnel who provide patient care is increasing, as a percentage of total unit producing personnel

Figure 31: Management and Support Personnel, by Year

	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13
Total Full Time Equivalents (FTEs)	57	58	56	57	62	60	61	58
Management and Other Support FTEs	9	10	9	5	6	6	5	4
Unit Producing Personnel FTEs	47	48	47	51	56	54	56	54
%UPP- Total Facility	83.4%	83.1%	83.3%	91.0%	89.8%	89.3%	92.1%	93.6%
%UPP- Patient Care	82.9%	82.9%	83.1%	94.9%	94.3%	94.6%	96.6%	98.6%
Administration and Support Services FTEs	19	19	19	19	22	22	20	20

Source: EDH Q4 OHRS Report

Englehart and District Hospital has partnered with other hospitals within the District and region to contract for select administrative and support services, including:

- The Chief Executive Officer is also responsible as the Executive Director of the Family Health Team.
- Human Resources expertise
- Health Records services (transcription, coding and abstracting)
- Integrated Director of Finance
- Integrated Chief Nursing Officer

- Occupational Health Nurse
- Integrated Lab Manager

5.10 Quality and Risk Management

During 2006, Englehart and District Hospital substantially revised its Quality Management Program. The organization also developed a hospital-wide Risk Management Program during the same year. Both of these programs focus on performance measurement and accountability, and include indicators monitored by both Englehart and District Hospital and the Ministry. They rely on a process that regularly establishes goals and objectives, and strives for continuous quality improvement. In 2011, Health Quality Ontario (HQO) began a Quality Improvement Plan process similar to the Quality program the Hospital already had in place. The Hospital is in full compliance with the HQO program. These programs are monitored by the Board of Directors.

5.10.1 Hospital Accreditation

Englehart and District Hospital participates in hospital-wide accreditation through Accreditation Canada. This process assesses whether the organization meets national standards in selected areas of operation.

The Hospital completed its latest Accreditation in June 2012. Follow up requirements were met on time in both November 2012 and May 2013. An additional requirement was satisfied on time in November 2013. The Englehart and District Hospital is fully Accredited.

Figure 33: Compliance with Accreditation Canada's High Priority Standards

Standards Section	EDH	Percentage
	Unmet	Met
Governance	2	91%
Effective Leadership	2	96%
Infection Prevention/Control	0	100%
Managing Medications	5	83%
Diagnostic Imaging	4	90%
Medicine Services	11	68%
Emergency Services	10	70%
Lab services (all)	0	100%

The stats for accreditation levels from the Accreditation Canada 2011 Report have a break down of the percentage of hospitals falling into the 4 different categories:
Accreditation with Exemplary standing is 30%
Accreditation with Commendation 25%
Accreditation is 44%
Not accredited is 1%

5.11 Information Management

The hospital participates with a consortium of eighteen other hospitals located throughout North East Ontario for the purpose of sharing an information system and having access to a shared North East regional electronic health record. Along with the other Northeastern Ontario Shared Information System (NEON) members, Englehart and District Hospital shares software, centralized hardware and data storage facilities supporting requirements in: Finance, Accounts Payable, Billing/Accounts Receivable, Materiels Management, Admissions/Registration, Inpatient Charting, Laboratory, and Diagnostic Imaging. Englehart and District Hospital has partnered with Kirkland and District Hospital and Temiskaming Hospital in integrating IT services. In addition these 3 hospitals are partner with Health Sciences North in the provision of IT services.

NE LHIN Integrated Health Services Plan emphasizes Information and Communication Technology (ICT) as a key enabler for all of its priorities. It further indicates that successful ICT projects will:

- Enhance patient care or access to services
- Be part of a regional strategic ICT plan
- Use a multi agency or multi sectoral partnership approach
- Have a sound business case
- Be usable as a foundational element in creation of an electronic health record

By continuing its participation in NEON and its integration of IT services, Englehart and District Hospital ensures access to a regional electronic health record while increasing its ability to implement further information technology projects that will benefit patient care or increase efficiencies.

5.12 Human Resources

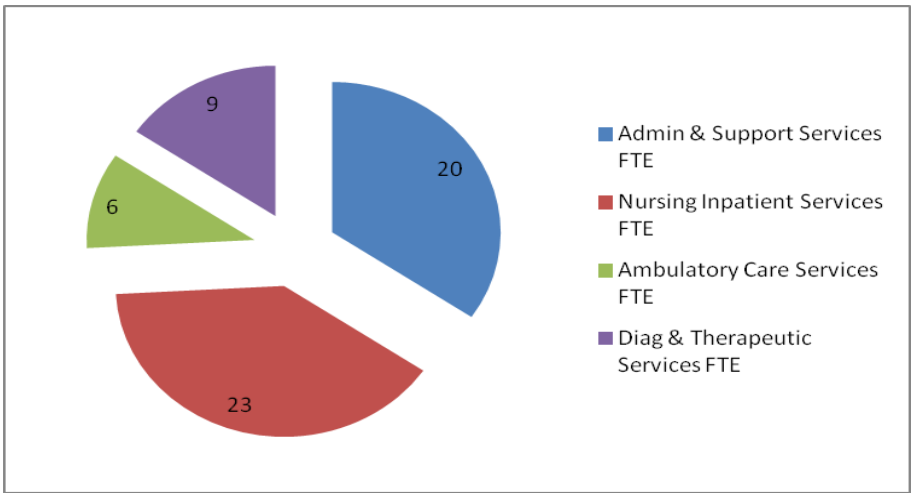
The Human Resources Department is staffed by one contracted Integrated Director and one full time Integrated Generalist who works one day per week at Englehart and District Hospital and four days per week at Kirkland and District Hospital
Englehart and District Hospital employs full-time and part-time staff. They are distributed among the broad service categories as show in the following table.

Figure 34: Full Time Equivalents and Productivity, by Year

	FY 0506	FY 0607	FY 0708	FY 0809	FY 0910	FY 1011	FY 1112	FY 1213
Staffing/Productivity								
Total Full Time Equivalents (FTEs)	57	58	56	57	62	60	61	58
Management and Other Support FTEs	9	10	9	5	6	6	5	4
Unit Producing Personnel FTEs	47	48	47	51	56	54	56	54
% of Full-Time Nurses	71.5%	69.8%	60.7%	68.7%	69.0%	74.6%	69.8%	51.8%
% Paid Sick Time- FT (%of Total UPP Hrs)	3.3%	3.2%	3.6%	2.6%	4.1%	4.4%	4.7%	5.5%
% Paid Overtime- FT (% of Total UPP Hrs)	1.3%	0.9%	1.6%	2.5%	3.2%	2.7%	3.4%	2.5%
% Paid Overtime- PT (% of Total UPP Hrs)	2.4%	2.9%	3.2%	3.7%	2.9%	3.8%	4.0%	3.4%

Figure 35: Full Time Equivalents by Area of Service, by Year

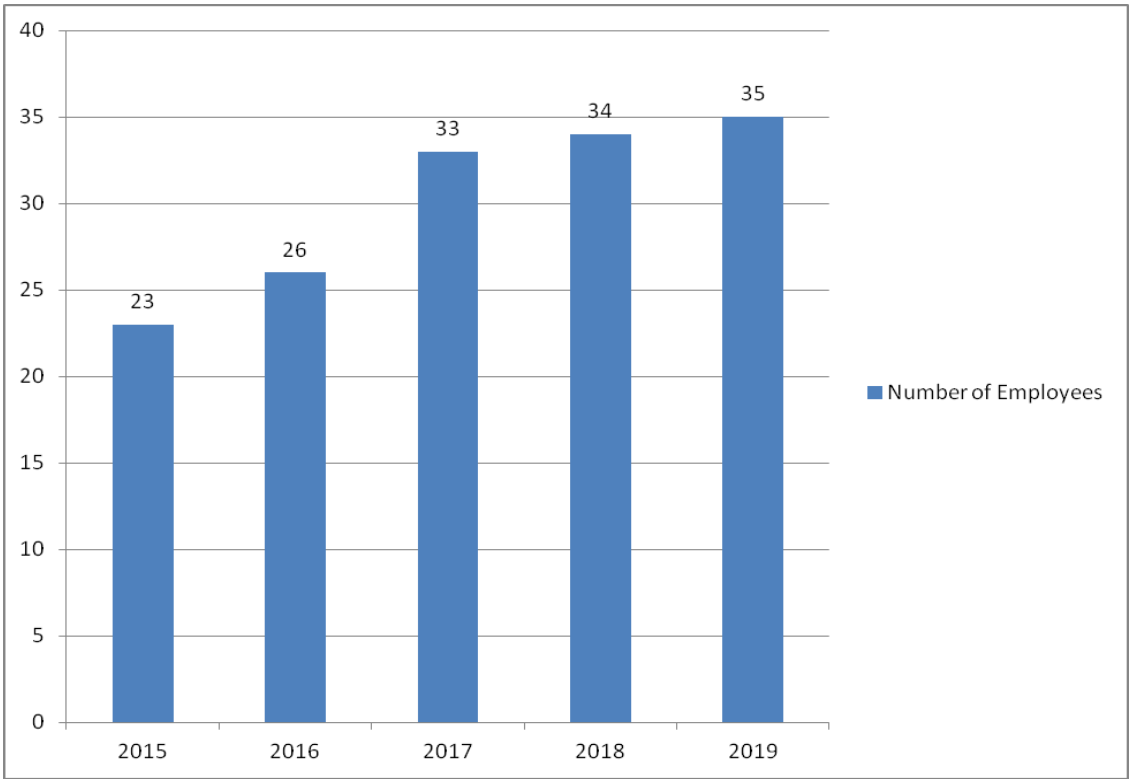
	Englehart and District Hospital									KDH	TH
	FY 0506	FY 0607	FY 0708	FY 0809	FY 0910	FY 1011	FY 1112	FY 1213		FY 1213	FY 1213
Admin & Support Services FTE	19	19	19	19	22	22	20	20		66	na
Nursing Inpatient Services FTE	21	22	21	22	24	23	26	23		49	na
Ambulatory Care Services FTE	8	9	7	7	7	6	6	6		27	na
Diag & Therapeutic Services FTE	9	8	8	8	9	9	9	9		28	na
Total FTE	57	58	55	56	62	60	61	58		170	na
% Admin $ Support	33.3%	32.8%	34.5%	33.9%	35.5%	36.7%	32.8%	34.4%		38.8%	na



Some of the employees of the hospital are represented by one of two different unions. The Ontario Nurses Association (ONA) represents the registered nurses who work at the hospital. The Laborers' International Union of North America (LIUNA) represents diagnostic, therapeutic and clerical staff in one Local and the Registered Practical Nurses (RPN) in another local.

5.12.1 Retirement

	2015	2016	2017	2018	2019
% of Potential Retirements	25%	28%	36%	37%	38%



There are several factors that, taken together, create a significant human resources challenge for Englehart and District Hospital to overcome over the next few years. Fully 38% of the hospital's employees will be eligible to retire during the next five years. This is significantly greater than the average of 30% among all Ontario hospitals.

As is typical when vast member of senior staff retire, a significant knowledge drain from the organization will occur over the next five years.

Like physician recruitment and retention, staff recruitment and retention already represents a significant organizational challenge, which will become even greater as time passes. Employee recruitment and retention will require significant time, effect and resources to address.

5.12.2 Sick Time and Injury

Sick time continues to play a significant factor as our employee body ages. Programs such as the Third Party Healthcare Adjudicator program and increased Occupational Health involvement in absence management have reduced the amount of incidental absences. Employee incidents have stabilized recently and the number of lost days to incidents has been reduced significantly, with 2 of the last 4 years having no lost time incidents or days. Increased training has assisted in this reduction as well as the installation of equipment, such as lifting devices.

Figure 37: Employee Incident Summary, by Year

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Number of Incidents	22	20	11	14	9	16	12	11	12	16
Number of Incidents with Lost Time	7	2	1	1	1	1	0	1	1	0
Number of Days of Time Lost	9	9	7	4	28	0	0	1	2	0
Number of WSIB Claims	9	6	3	5	4	4	2	2	2	8

5.13 Finance

In the six year period for 2007/2008 until 2012/2013 total revenues have increased by 8.7% an average of 1.5% per year. In the same period, overall expenses increased by 10.9%, an average of 1.8% per year. Wages and Benefits increased by $543,728 or 13.4%, an average annual increase of 2.2%. Medical and surgical supplies increased $28,530 or 34.6%, averaging 5.8% per year. Equipment expenses increased $35,702 or 20 % averaging 3.3% per year. While supplies and other expenses increased $44,592 or 4.8%, the second largest impact over these six years is

referred out expenses, largely due to the cost of sending diagnostic tests, such as diagnostic imaging and laboratory tests, to other facilities due to equipment limitations at our hospital. These costs increased $133,214 or 78.5%, an average annual increase of 13.1%.

In 2011/2013, in response to declining revenues, Administration reduced operating expenses in virtually every category and reduced the previous periods' deficit by $72,290 or 34.6%.

Most concerning is that the decline in revenues may continue as the focus on reducing Alternate Level of Care patients continues with little or no increase in Ministry of Health and Long Term Care revenues. At the same time, arbitrated labour settlements and other inflationary pressure in food and energy sectors will continue to push expenses up. In addition the resulting operating deficits will continue to eat up cash reserves, which are typically used for equipment modernization.

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Total Revenue	$6,246,527	$6,550,776	$6,849,067	$6,870,024	$7,060,710	$6,790,786
Total Expenses	$6,245,792	$6,437,320	$7,202,665	$6,924,692	$7,269,882	$6,927,667
Surplus/(Deficit)	$735	$113,456	-$353,598	-$54,668	-$209,172	-$136,881

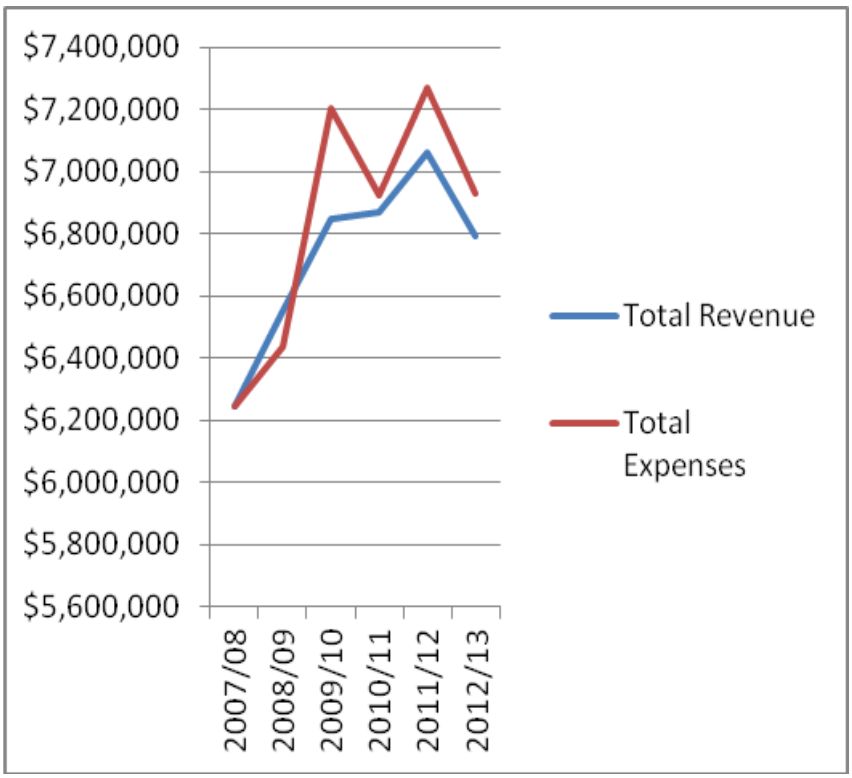


Figure 38: Total Operating Revenue and Expense, by Year

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
MOHLTC Revenue	5,127,179	5,271,716	5,433,932	5,434,523	5,682,633	5,579,635
Other Revenue	1,119,347	1,279,060	1,415,135	1,435,501	1,378,078	1,211,151
TOTAL REVENUE	6,246,527	6,550,776	6,849,067	6,870,024	7,060,710	6,790,786
Wages and Benefits	4,059,556	4,146,123	4,575,827	4,615,090	4,758,743	4,603,284
Medical Staff Remuneration	258,007	256,695	280,824	264,828	279,641	244,788
Medical and Surgical Supplies	82,346	110,625	121,524	101,264	127,560	110,876
Drugs and Medical Gases	110,277	99,081	126,342	123,391	139,158	115,994
Bad Debts	112	3,954	17,076	-2,520	15,021	19,438
Equipment Expense	178,272	249,337	291,951	217,243	244,729	213,974
Equipment Depreciation	309,206	315,099	376,376	320,161	305,602	250,742
Referred Out Expenses	169,686	239,697	299,654	301,926	390,243	302,900
Buildings and Ground Expense	148,835	106,567	98,509	78,099	93,237	91,587
Supplies and Other Expenses	929,492	910,141	1,014,525	905,210	915,948	974,084
TOTAL EXPENSES	6,245,792	6,437,320	7,202,665	6,924,692	7,269,882	6,927,667
SURPLUS / (DEFICIT) FOR MOH	**735**	**113,456**	**(-353,600)**	**(-54,668)**	**(-209,171)**	**(-136,881)**
ADD: Amort of Donations/Grants	54,491	2,083	56,149	84,471	87,335	92,251
LESS: Other Depreciation	130,801	163,375	224,738	230,129	239,357	229,947
SURPLUS / (DEFICIT)	**(-75,575)**	**(-47,836)**	**(-522,188)**	**(-213,154)**	**(-361,193)**	**(-274,577)**

Figure 40: Balance Sheet, Last Three Years

	2010/11	2011/12	2012/13
CURRENT ASSETS			
Cash	757,271	676,406	750,023
Investments	517,861	306,227	410,970
Accounts Receivable (Net of Allowance for Bad Debts)	235,110	221,796	297,173
Inventories	108,411	131,874	129,671
Prepaid Expenses & Deferred Charges	42,214	41,789	33,653
Total Current Assets	**1,660,867**	**1,378,092**	**1,621,490**
NON CURRENT ASSETS			
Property, Plant & Equipment (Net of Accumulated Amort.)	**4,988,251**	**4,532,057**	**4,211,545**
TOTAL ASSETS	**6,649,118**	**5,910,149**	**5,833,035**
CURRENT LIABILITIES			
Accounts Payable and Accrued Liabilities	621,914	715,403	833,007
Current Portion of Long Term Debt	30,000	-	-
Total Current Liabilities	**651,914**	**715,403**	**833,007**
LONG TERM LIABILITIES			
Long Term Debt	512,500	-	-
Deferred Grants and Donations	2,774,289	2,978,324	3,058,184
Total Long Term Liabilities	**3,286,789**	**2,978,324**	**3,058,184**
NET ASSETS			
Unrestricted	**2,710,415**	**2,216,422**	**1,941,844**
TOTAL LIABILITIES & NET ASSETS	**6,649,118**	**5,910,149**	**5,833,035**

6.0 STRATEGIC PLANNING INPUT

This strategic planning session principally consisted of a detailed review by the Senior Team, Managers and the Board of Directors of six major factors:

1) Previous Strategic plan of Englehart and District Hospital
2) Current Community inputs from Board members and NE LHIN Integration Sessions
3) Ongoing dialogues with health care partners through joint sessions including both the Joint Executive Committee, the Englehart and Kirkland Hospital Planning Committee (EKHPC) and both the Timiskaming and Cochrane District collaborative, as well as the Timiskaming Health Links.
4) The Englehart and District Hospital Operations Plan
5) The joint operation structure of the Englehart and District Hospital and the Englehart and District Family Health Team
6) Review of the MOHLTC and NE LHIN Strategic Plans for Alignment

6.1 PREVIOUS STRATEGIC PLAN

After much review it was decided by the planning group that the 2009 to 2013 Strategic Plan did not require major changes. The goals and objectives only required minor adjustments to update for changes in other strategic directions, such as MOHLTC and the NE LHIN as well as updated terminology.

6.2 CURRENT COMMUNITY INPUTS

By far and away, the most consistent message given by community members to the NE LHIN at their community engagement session in 2012 were

a) Current hospital services cannot be cut
b) The Hospital must be involved in fixing the Long Term Care problems in Englehart area.

6.3 HEALTH CARE PARTNERS

We continue to work with our health care partners in these many venues to address patient centered service delivery, including focusing on service gaps, integration of back office and patient services.

6.4 OPERATIONS PLAN

The Operations Plan and related Balanced Score Card are attached as Appendix B. This plan was developed with the active involvement of all employees and has been our guiding light

with an increased focus due to our tight resources and continued financial deficits. The Score Card allowed us to both track and communicate our results based on our plan. This Score Card was reviewed by the Board or Directors and all Management employees monthly. The process used for the Plan is well detailed in the opening discussion.

6.5 JOINT OPERATIONS STRUCTURE

The Board Chair of the Hospital is also the Board Chair of the Family Health Team. Several Board members also serve on both Boards. As well, the Chief Executive Officer of the Hospital is also the Executive Director of the Family Health Team. This relatively unique organization structure allows much closer contact with primary care. Integrated meetings are held between the Family Health Team Coordinator and the Nursing Manager to coordinate Emergency Room and Clinic traffic and volumes. As well, the Family Health Team Coordinator attends hospital Senior Management meetings on a weekly basis and the Hospital Strategic Planning session.

6.6 MOHLTC AND NE LHIN

Both the MOHLTC and the NE LHIN Strategic Plans were reviewed to ensure alignment of the Englehart and District Hospital Strategic Plan.

During the Strategic Planning process the team also completed a Strengths, Weakness, Opportunities and Threats (SWAT) Analysis.

7.0 STRATEGIC DIRECTIONS

Englehart and District Hospital is a well run hospital with a solid track record for positive performance, as measured objectively by past financial performance, Ministry performance indicators and other third party assessments. The hospital is recognized by its employees and organizational partners for the quality of its patient care, for excellent relations with the community and for the support that the community has given to the hospital, and for the caliber of its staff.

Over the past years, the hospital has done the right things to adapt to challenges - decreasing the number of management positions and staff, partnering and integrating with other organizations for management and administrative services, and adjusting the mix of skills employed in select areas, for example. The most recent financial pressures, however, have caused the hospital's fortunes to change, as the cost of wages and salaries, and other key expense lines, has outstripped Ministry funding increases.

With a reduced complement of management staff and the additional work required to meet new legislative and reporting requirements, the hospital has a limited capacity to tackle new initiatives.

The recruitment and retention of both employees and physicians is an issue that currently challenges the Englehart and District Hospital. It takes an ongoing commitment of time, energy, effort and resources to ensure the physician and staff complement required to support the needs of the community. As the number of staff who are eligible to retire increases, this issue will only become a greater pressure.

The facility's built structure also challenges the employees who work there to provide necessary care, because of inadequate space and accessibility.

Employees, organizational partners, and community members agreed that the one thing that Englehart and District Hospital should do to make the biggest, most positive difference for the community it serves is to build long term care places or provide long term care and become a district centric partner.

Factoring all of the information presented in this report into their decision making, the Board of Directors of Englehart and District Hospital has chosen to move forward with three major strategic directions after reviewing and revising the Strategic plan in October 2013.

Strategic Direction 1: Quality Culture – The Hospital embraces a culture of Quality which is patient centered, utilizes best practices and optimizes health outcomes.

Objective 1a: All Accreditation Standards of excellence will be met to improve patient care and health outcomes.

Objective 1b: Meet all "Excellent Care for All Act" legislated requirements annually.

Objective 1c: Create a quality culture that will enable the reporting of critical events and near misses by focusing on process improvements and staff accountability.

Objective 1d: Continuously improve patient safety by benchmarking against best practices, redesigning processes and by continuously measuring and communicating result.

Big Hairy Audacious Goal: Exemplary Standing by Accreditation Canada in 2015 Survey.

Strategic Direction 2: Effective Resourcing- Englehart and District Hospital will continue to provide the entire range of hospital services consistent with the Ministry of Health and Long Term Care's Joint Policy and Planning Committee recommended core services for small hospitals.

Objective 2a: Operate within the established operating and capital budgets while investigating other options.

Objective 2b: Ensure sufficient staff human resources to meet operational needs.

Objective 2c: Ensure sufficient physician resources to meet the community's needs.

Objective 2d: Investigate and implement, where it is beneficial to do so, opportunities for horizontal and vertical integration of services.

Big Hairy Audacious Goal: Advance the new Health Care Facility project to gain MOHLTC commitment for a full service, geocentric facility for the district.

Strategic Direction 3: Community Leadership- Englehart and District Hospital will continue to work with other health care, social services, and planning partners to enhance services for seniors across the spectrum of care, specifically focusing on long term care.

This requires the organization to focus on three distinct areas:

Objective 3a: Pursue the establishment of long term care spaces

Objective 3b: Link with community partners to provide greater support for residents in their own homes, through such services as: outreach clinical services, home support, and meal on wheels. Explore the feasibility of alternate bed types, for example: rehab and assisted living.

Objective 3c: Refine existing hospital services.

Big Hairy Audacious Goal: Lead the development of a respectful Assisted Living Community.

In 2006, the Joint Policy and Planning Committee (JPPC) recommended to the Ministry of Health and Long Term Care (the Ministry) the following list of core services for small hospitals:

- An Emergency Department prepared to provide care, or stabilize and transfer, medical, surgical and mental health patients entering via the department ;
- Acute Care Inpatient Medical Beds;
- General Practitioners/Family Physicians supported by broadly-trained Nurses;
- Inpatient Allied Health Services (Physiotherapy, Clinical Nutrition, Occupational Therapy, Respiratory Therapy, Speech Pathology and Pharmacy); and
- Laboratory, Ultrasound, General Radiography and Non-invasive Cardiology.

The Board of Directors has determined that Englehart and District Hospital will continue to operate inpatient acute care services as part of its commitment to fulfill the mandate of a small hospital, as defined by the JPPC, and as highly valued by the community.

The need for enhanced services for seniors in Timiskaming is undeniable. The 2011 census shows that one in every three citizens is over the age of 55, trending upward from the previous census. This relative agedness is significantly higher than the Ontario average, in which just one in four of the population is at least 55 years old. The area's population is also declining, down

2.9% from the previous census to approximately 8,000 Central Timiskaming residents recorded in 2011. With out-migration of local young people to southern cities for higher education, first, then employment, the local population consists largely of elder citizens, who are aging in place. The existing places available in the local long term care facility, and in similar facilities throughout the District, are virtually 100% occupied. .

The local long term care facility is a Schedule C facility with significant structural issues. It is understood that this facility's license will not be renewed unless major capital investments are made. Economies of scale in operating the current, 48-bed standalone facility make it unlikely that the required capital investment will have sufficient payback to retain private sector involvement in provision of these services locally.

There is a notable absence of privately funded assisted living or 'retirement home' accommodation within the District. As with residential long term care, this reflects the challenge of achieving economies of scale and the difficulty for a private organization to earn a profit by providing this service to small populations. It is a significant factor contributing to higher local per capita requirements for long term care beds.

The requirement to inappropriately and expensively accommodate people with long term care needs in acute care beds will continue and will increase, unless action is taken by local organizations and the planning bodies that support them.

Englehart and District Hospital is ideally positioned to lead and participate in these initiatives for the following reasons:

- Adding long term care places to the existing complement of acute care and complex continuing care beds allows for greater economies of scale in administrative and support services. It likely makes the best sense, financially.
- Organizational partners view the hospital and its management staff very positively, acknowledging them as leaders. Relationships with other private and public partners are well established and will serve as the foundation for the work required to enhance services for seniors.
- Local residents have demonstrated time and again their overwhelming capacity to contribute to capital fundraising campaigns - for hospital equipment, and for hospital renovations, and for related projects to accommodate first the medical staff and then the Family Health Team.

There are already well established models within North East Ontario to refer to, both from the perspective of development and implementation of long term places in conjunction with an acute care facility, and in relation to their ongoing operations.

On behalf of the community that it serves, the Board of Directors of Englehart and District Hospital will engage with the Ministry, the North East LHIN, and local organizational partners to determine how to best serve the needs of local seniors through the creation of new long term care places. At the same time, the organization will work with its partners to refine the services

offered internally to seniors and to provide greater support for residents to sustain them in their own homes for as long as possible. The ability for the new facility and the repurposed Hospital facility to address district health care gaps will be the primary focus for the Hospital in the current Strategic Plan.

By focusing on achieving these two strategic directions over the next three years, the Board of Directors of Englehart and District Hospital intends to make a significant, positive difference on behalf of the community that it serves. This will propel the hospital even closer to its vision to be:

- A leader in Quality health care services.
- A collaborative workplace for the entire health care team.
- An innovative and valued partner in our community, respected by our peers.

Appendix A: List of Figures

APPENDIX B- OPERATIONS PLAN

Englehart & District Hospital
2012 - 2014 Operations Plan

EDH

Englehart & District Hospital
2012 – 2014 Operations Plan
Together, We Care

Executive Summary

The 2012 Operations Plan for the Englehart & District Hospital will cover 18 months rather than the traditional 12 months because of the late start this year. The Plan is based on the findings of the Accreditation Canada audit, the Ontario Laboratory Assessment and the Operations Reviews that were conducted in June 2012. It is the culmination of input from recognized quality care leaders and the vast majority of our dedicated employee and physician body through no less than 10 meetings and information session. As well, all clinical employees received 1 on 1 information gathering sessions, with an astounding 95% attendance rate. In the end, the Senior Team was able to categorize the 246 recommendations received from our employees and physicians into four main "Pillars of Success":

Patient Centered;
Staff Engagement;
Professional Culture; and
Financial Responsibility.

The Senior Team developed 5 "Pillar Descriptors" and a "Vision Statement" for each Pillar to better define the expectations or the values each Pillar represented. With these four Pillars in mind, the Senior Team developed the Initiatives that will be worked on to ensure we achieve the Plan that our team developed. These descriptors and initiatives are further outlined below.

Finally, the Team developed the motto for the Operations Plan – "Together, We Care". The motto has two purposes, 1) to remind our community and 2) to ensure all staff appreciate that it takes all of us to provide the care that our patients require. Whether they work in direct patient care or in patient support services, it takes all of us.

The Board of Directors approved the Operations Plan at the Strategic Planning Retreat on September 28, 2012.

I am excited at the process we have undertaken and confident that the plan we have developed together will ensure the sustainability of our hospital and I look forward to working together with our team in implementing our plan.

Mike Baker
Chief Executive Officer

Englehart & District Hospital
2012 – 2014 Operations Plan
Together, We Care

Pillar Number 1 – ***Patient Centered***

Pillar Vision Statement - ***"We are Focused on Our Patients"***

Pillar Descriptors –

1) Safe – We will provide care that brings no harm to any patient.

2) Quality – We will provide care based on the best practices and procedures available.

3) Accessible – We will provide the care patients require or assist them in obtaining care we can't provide.

4) Appropriate- We will provide the level of care with the right resources and support Home Care Initiatives.

5) Compassionate- We will provide a level of care that respects the patient's needs as if they were our own family member.

Pillar Initiatives –

1) Ontario Laboratory Assessment – Carol Halt – Due September 20, 2012.

Goal - Successfully address the non-compliance items from the audit.

Measurable – OLA Accreditation.

2) Accreditation Canada – Carol Halt – Phase 1 Due November 13, 2012.

- Phase 2 Due May 2013.

Goal – Successfully address the non-compliance items from the audit.

Measurable – Accreditation Canada Accreditation.

3) Pharmacy Review – Carol Halt – Due 2014

Goal – Complete review and redesign of Pharmacy, including dispensing practices, (unit dosing), risk mitigation, materials management, Information Technology investment and human resourcing.

Measurable – implementation of a highly efficient and sustainable process.

Englehart & District Hospital
2012 – 2014 Operations Plan
Together, We Care

Pillar Number 1 – ***Patient Centered***

Pillar Initiatives –

4) Staff Scheduling & Structure Review – Carol Halt – Due 2013

Goal – Review of staffing elements in all clinical areas, including Laboratory, Diagnostic Imaging, In-patient Nursing and Emergency Room Nursing, with a focus on shift scheduling, shift make up, human resourcing and patient assignments.
Measurable- 10% reduction in overtime and premium costs for the same patient load factors of occupation and Emergency Room Visits and Acuity.

5) Way Point Committee – Mark Montminy – Due 2013

Goal – Review the current methods of communicating to both in and out patients both directional and instructional information.

Measurable – Increased information to patients while reducing the clutter and increasing the professional look of the facility.

6) Triage Registration Review – Carol Halt – Due 2014

Goal – Review the ability to triage patients before registration during all hours of everyday and regardless of the availability of Registration staff.

Measurable – Objective, evidence-based decision on the ability to change the process and addressing patient safety.

7) Senior Friendly Hospital Review – Carol Halt – Due 2014

Goal – Review our compliance to Senior Friendly Hospital initiatives and recommend sustainable improvements.

Measurable - Objective, evidence-based decision on the ability to change the process and addressing patient safety

Englehart & District Hospital
2012 – 2014 Operations Plan
Together, We Care

Pillar Number 2 – ***Staff Engagement***

Pillar Vision Statement - ***"We are Proud to Work Here"***

Pillar Descriptors –

1) Development – We will provide the training that our staff requires to provide the level of care our patients require.

2) Recognition – We will take the time to celebrate our successes.

3) Inclusive – We will include employees in the development of plans.

4) Respectful- We will treat each other as we wish to be treated and recognize the contributions that we all make in serving the patient.

5) Equitable- We will treat each other with fairness and ensure that all employees have the opportunity to participate when appropriate.

Pillar Initiatives –

1) ***Staff Engagement Survey*** – Christine Brownlee – Due 2012.

   Goal – Develop a survey that is compliant with ECFAA and will provide meaningful analysis of the engagement of our staff so we can make evidence-based decisions on how to improve engagement and measure future improvement.

   Measurement – Implementation of a cost effective & informative survey system.

2) ***Performance Management System*** – Debra Schenk – Due December 31, 2012.

   Goal – Develop an annual, participatory system that measures performance against standards and measures and includes a development and succession program for each employee. It will also be tied to the budget cycle.

   Measurable – Implementation of the system by December 31, 2012. Increased participation rates over the previous system.

Englehart & District Hospital
2012 – 2014 Operations Plan
Together, We Care

Pillar Number 3 – ***Professional Culture***

Pillar Vision Statement - ***"The Best Want to Work Here"***

Pillar Descriptors –

1) Professional – We will act in a professional manner at all times.

2) Standards– We will work to the professional standards we trained so hard to achieve.

3) Full Scope – We will work to the highest level of competence our standards allow.

4) Team - We will work together to improve patient care through the synergy developed.

5) Communication - We will use all mediums of communication to ensure the most effective care.

Pillar Initiatives –

1) ***Staff Newsletter*** – Mike Baker – Due 2012.

   Goal – Develop a communication vehicle for staff.
   Measurable – communication vehicle in place by December 31, 2012.

2) ***Regular Staff Meeting Schedules*** – Mike Baker – Due 2012

   Goal – Ensure all departments are holding regular staff meetings to discuss current issues, as well as safety, program and financial topics.

   Measurable – receive confirmation from each Senior Team member and attend at least one meeting for each department.

3) ***Scope of Practice Review*** – Carol Halt – Due 2013.

   Goal – increase efficiency by ensuring all staff are trained in and working to the full scope of practice.

   Measurable – Completion of training by June 30, 2013 and 10% reduction in overtime and premium costs for the same patient load factors of occupation and Emergency Room Visits and Acuity.

Englehart & District Hospital
2012 – 2014 Operations Plan
Together, We Care

Pillar Number 3 – ***Professional Culture***

Pillar Initiatives –

4) Professional Practice Model – Carol Halt – Due 2013.

Goal – Develop the structured system and ensure tools are available to implement professional practices.

Measurable – Professional Practice Model fully implemented by December 31, 2013.

5) Revamp Recruiting & Retention – Debra Schenk – Due 2014.

Goal – Complete review and revamp (as appropriate) of the recruiting and retention process based on a study of best practices. Include the opportunity to tie in physician recruitment as well.

Measurable – Completion of a new recruitment and retention plan by December 31, 2014.

Englehart & District Hospital
2012 – 2014 Operations Plan
Together, We Care

Pillar Number 4 – ***Fiscal Responsibility***

Pillar Vision Statement - ***"We Provide Sustainable Health Care"***
Pillar Descriptors –

1) Accountable – We will do what we say we will do.

2) Knowledgeable– We will know our business and how our decisions impact our patients.

3) Evidence – We will use evidence and business models to make educated decisions and plans.

4) Integrated - We will proactively research and justify the use of integration opportunities.

5) Patient Focused - We will make decisions that best suit our patient's needs while considering the sustainability of those decisions.

Pillar Initiatives –

1) ***Referred Out & Call Out Review*** – Sean Conroy – Due 2012.

   Goal – To review, in a business model, the costs of referred out, call in and call out costs to reduce costs while maintaining patients services.

   Measurable – Reduction of referred out and premium costs by 15% by April 1, 2013.

2) ***Growth Opportunities Review*** – Mike Baker – Due 2014.

   Goal – Continued focus on patient service alignment in the area, including business model evaluation of potential opportunities.

   Measurable – Review and decision on one opportunity per year.

Englehart & District Hospital
2012 – 2014 Operations Plan
Together, We Care

Pillar Number 4 – ***Fiscal Responsibility***

Pillar Initiatives –

3) ***Integrated Services Participation*** – Mike Baker – Due Ongoing.

   Goal – Continued active participation in all integration initiatives including initiatives between the 3 hospitals, the Temiskaming Collaborative, the Network 13 Collaborative programs and support of the Joint Executive Committee.

   Measurable – 100% attendance at integration meetings and commitment of resources to those initiatives that make sense.

4) ***Capital Equipment Review*** – Sean Conroy – Due 2013.

   Goal – Establish a 5 year capital program, including project justification based on our 4 pillars of success for each project and an annual Board approval of the plan.

   Measurable – start project justification by September 2012 and annual Capital Approval with the 2013/2014 Budget process.

5) ***Financial Reporting Redesign*** – Sean Conroy – Due 2013.

   Goal – redesign financial reporting to increase transparency and understanding of the financial reports as well as providing better tools to forecast results and to make evidenced based decisions.

   Measurable – Implementation of a reporting system by April 1, 2013.

6) ***Policy & Procedure Process Review*** – Sean Conroy – Due 2014.

   Goal – To review and modify financial policies, procedures and processes for consistency between the two hospitals.

   Measurable – Completion of the review by December 31, 2014.