Services de santé du
TIMISKAMING
Health Unit

Strategic Plan 2012-2017

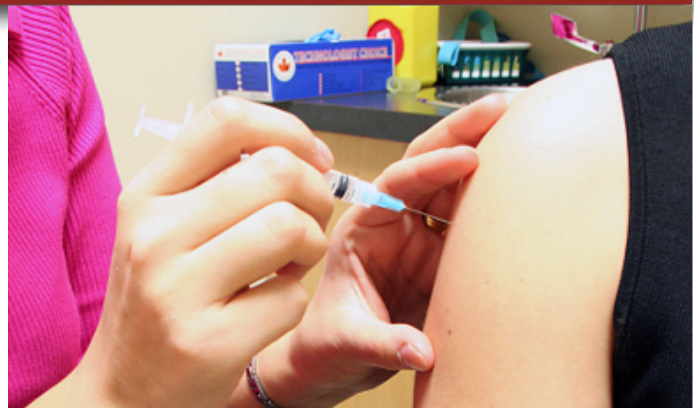

Table of Contents

1.0 Introduction and Background 5
1.1 Overview of the Strategic Planning Process 7
1.2 The Appreciative Inquiry Approach to Strategic Planning 8
1.3 The Strategic Planning Working Group 9
1.4 Report Overview 9

2.0 Stakeholder Engagement Strategy 10
2.1 Engagement Methods 10
2.2 Sources of Input 10
2.2.1 Online surveys 10
2.2.2 Employee summits 11
2.2.3 Stakeholder interviews 11
2.2.4 Public consultation sessions 11

3.0 SWOT Analysis and Environmental Scan 12
3.1 SWOT Analysis Summary 12
3.2 Strengths 13
3.2.1 External communication and program promotion 13
3.2.2 Experts at data gathering and providing info to stakeholders 13
3.2.3 Capacity/skills building, resource sharing 14
3.3 Weaknesses 15
3.3.1 Some programs duplicate services from other organizations 15
3.3.2 Relationships with some partners could improve 16
3.3.3 Poor customer service for some clients, e.g. Francophone, Aboriginal 17
3.3.4 Challenges working within union environment 18
3.3.5 Lack of direct management guidance in most offices 18
3.3.6 Poor internal communication between departments, offices, programs 19
3.3.7 Lack of strong HR management to ensure staff are trained, motivated 19
3.4 Opportunities 20
3.4.1 Changing/emerging demographics, e.g. seniors, Aboriginals, youth, etc. 20
3.4.2 Reduce service duplication 20
3.4.3 Gaps/needs assessments for priority and at-risk populations 21
3.4.4 Internet and social media usage 22
3.5 Threats 23
3.5.1 Area struggles with attracting new, qualified people 23
3.5.2 Outside organizations' activities can have negative implications 24
3.5.3 Funding and accounting pressures 24
3.5.4 Integration of health organizations may not be conducive to THU 24
3.6 Environmental Scan 25

3.6.1 People and demographics 25
3.6.2 Health challenges 27
3.6.3 Socioeconomic factors 29
3.6.4 Technology 30
3.6.5 Political factors 32

4.0 The Dream Phase 34

5.0 The Design Phase: Developing Tactics 36
5.1. Community Wellness Link 36
5.1.1 Conduct a program and services review 37
5.1.2 Develop an organizational marketing strategy 38
5.1.3 Develop a quality management process for client service delivery 38
5.2. Building Health Capacity 39
5.2.1 Determine local baseline statistics for health indicators 39
5.2.2 Set measurable targets for health indicators 40
5.2.3 Conduct program and service reviews to address unmet needs 41
5.2.4 Refine partnership and collaboration framework 41
5.3. A Workplace of Choice 41
5.3.1 Invest in employee development 42
5.3.2 Develop a comprehensive human resources strategy 43
5.3.3 Secure OCCHA Accreditation 44
5.4. Communications and Knowledge Excellence 45
5.4.1 Invest in management development 46
5.4.2 Develop an organizational communications strategy 47
5.4.3 Develop knowledge management protocols based on best practices 48

6.0 The Delivery Phase: Implementation 50
6.1 Best Practices for Implementing Strategic Plans 52

Appendix A: Organizational Partners Consulted 54
Appendix B: Ontario's Action Plan for Health Care - Highlights 56
Appendix C: Selected Health-related Items from the Ontario Budget 2012 59
Appendix D: Selected Recommendations from the Drummond Report 62

Executive Summary

The Timiskaming Health Unit (THU) provides public health programs and services to a diverse group of stakeholders, clients, and members of the public in the Northeastern Ontario region of Timiskaming. Communities served by the THU include Temiskaming Shores, Kirkland Lake, Englehart, Elk Lake, and Matachewan.

This report outlines the process and results of the THU's 2012 strategic planning exercise. The purpose of this strategic plan is to provide direction and guidance for operational decision making for the period of 2012-2017. The strategic planning process utilized an Appreciative Inquiry approach to understand and leverage the organization's key strengths. The stakeholder engagement process included employee summits, interviews with partners and other community organizations, and surveys of the general public. The consulting team also conducted SWOT and environmental scans, as well as an analysis of relevant documentation and a literature review.

The consultations confirm that the community at large has an excellent general awareness of THU programs and services, and that the THU holds leadership and expert status in the health sector. However, there is some uncertainty –both internally and externally– around the THU's strategic role and mandate in the context of regional health care. In addition, respondents identified communication challenges that are complicated by a multi-location, multi-cultural linguistic service delivery requirement. Opportunities include establishing greater awareness of the social determinates of health, taking a leadership role in reducing regional program duplication, and identifying health service gaps. One of the THU's major challenges is in attracting qualified staff, an issue compounded by succession planning requirements and a robust regional economy.

The four strategic directions build on the THU's current strengths and mitigate external challenges. They include:

Become a Community Wellness Link: Leverage expert status and establish the THU as the Community Wellness Link (the "go-to agency") for all sectors of the population.

Build Health Capacity: Help individuals and organizations develop greater self-efficacy and empowerment in supporting wise lifestyle decisions and public policy development.

A Workplace of Choice: Work towards becoming an employer of choice, measured in terms of staff identification, commitment, retention, and positive workplace culture.

Communications and Knowledge Excellence: Establish seamless and accessible communication in all offices. Secure the infrastructure, applications and training needed to facilitate effective knowledge sharing, distribution and information management.

1.0 Introduction and Background

The Timiskaming Health Unit (THU) is one of thirty-six Health Units in Ontario. THU provides services to the Timiskaming region in Northern Ontario with offices located in Temiskaming Shores, Kirkland Lake, and Englehart. The THU also sponsors two nursing stations, one each in Elk Lake and Matachewan.

Public Health Units fall under the Ministry of Health and Long-Term Care (MOHLTC) and the legislated mandate of the Health Units is to deliver public health programs, prevent the spread of disease, and promote and protect the health of the people of Ontario[1]. Health Units are responsible for providing public health programs and services that contribute to the physical, mental, and emotional health and wellbeing of the population. Health Unit activities must be designed to address the Social Determinants of Health (SDOH), promote the health of the population as a whole, and work with community partners to reduce the health inequities of the regional population.[2]

THU provides a variety of services to promote health and prevent disease including:

- Chronic disease prevention
- Prevention of injury
- Reproductive and sexual health
- Child health
- Infectious disease prevention and control
- Addictions counseling
- Substance misuse prevention, smoking cessation, tobacco control
- Mental health
- Food and water inspection
- Public health emergency preparedness

The Ontario Public Health Organizational Standards of MOHLTC establish the guidelines for effective management and governance requirements for Public Health Units. The Standards

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[1] Health Protection and Promotion Act, (HPPA) R.R.O., (R.S.O. 1990, c.H.7, s.2). Up to 55 other pieces

[2] Ministry of Health and Long-term Care. (2008). Ontario Public Health Standards. http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/progstds/pdfs/ophs_2008.pdf

mandate that the Boards of Health that govern Public Health Units shall develop a strategic plan that will, among other criteria, cover a three to five year time frame, express the goals and objectives of the organization, and establish strategic priorities to meet local needs and integrate local community priorities. The plan must also address how the Health Unit will meet the Ontario Public Health Standards (OPHS) established by the MOHLTC.[3] According to the OPHS, Health Unit planning must be guided by four key principles: Need, Impact, Capacity, and Partnership and Collaboration. The programs offered by Health Units are established by Foundational Standards to ensure that, across Ontario, there are fundamental and common public health programs and services. These programs and services fall into five key areas:

1. Chronic Disease and Injuries
2. Family Health
3. Emergency Preparedness
4. Infectious Diseases
5. Environmental Health

The above five program areas include the following components: assessment and surveillance, health promotion and policy development, disease and injury prevention, and health protection services.

In mid-2011, the THU hired a new Medical Officer of Health (MOH) and Chief Executive Officer (CEO). The introduction of new key senior management members–and the changing social, cultural, and health landscape of Northern Ontario– prompted the Board to develop new long-term goals for the organization at this time. They selected our firm, Clearlogic Consulting Professionals, to develop an organizational strategic plan in consultation with their own Strategic Planning Working Group (SPG). The SPG felt that the Appreciative Inquiry (AI) approach to strategic planning would be most appropriate for the organization. Together, the SPG and our firm developed a modified approach to AI that included a preliminary SWOT analysis in order to inform the development of an affirmative topic.

The purpose of the plan is to help guide the organization in its decision-making and activities towards a vision shared by key stakeholders, including employees, clients, partners and funders. This plan will rely on extensive research and stakeholder input to develop a strategic framework for activities over the next five years.

[3] Ontario Public Health Organizational Standards. Ministry of Health and Long-Term Care. 3.2. P. 14. http://www.health.gov.on.ca/en/pro/programs/publichealth/orgstandards/docs/org_stds.pdf

1.1 Overview of the Strategic Planning Process

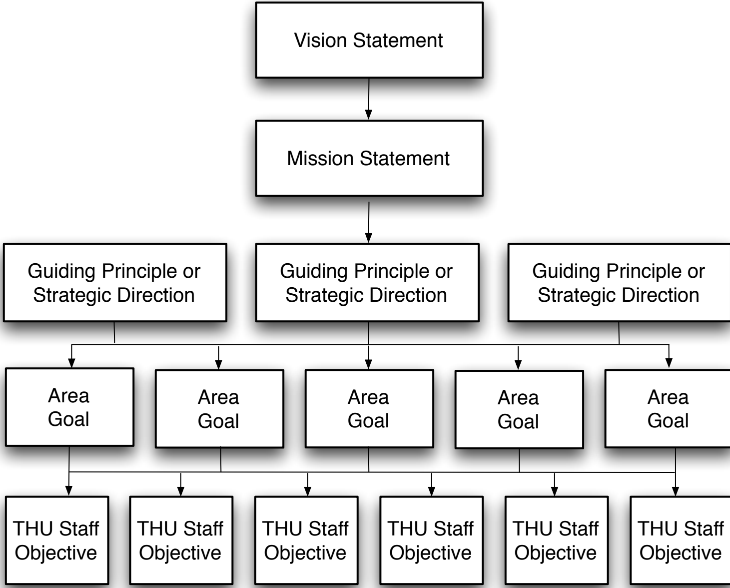
A strategic plan sets goals and priorities for an organization and develops a plan to achieve them. It involves stepping back from the front-line operations and examining how higher-level trends and developments will affect the organization over the long term.

Strategic planning is not only effective at helping focus and manage internal resources, but also helps reduce and mitigate external threats and risks. Ultimately, the strategic plan provides a decision-making tool for an organization, helping it determine which projects to pursue and how to allocate scarce resources.[4]

It's important to recognize that a strategic plan is not the same as a business or operational plan. These describe how an organization controls and measures its day-to-day tasks, and how it achieves short-term objectives. Operational plans are meant to improve the effectiveness of an organization without significantly changing its direction. In contrast, a strategic plan may involve changes in vision, mission or mandate to reflect external conditions and demands. Organizational plans may then be developed for individual directions or sections of the strategic plan.

Think of the strategic plan as "leadership" and the organizational plan as "management". See Figure 1.1 for an overview.

Figure 1.1: Operationalizing a strategic plan



[4]Bryson, J. M. (2004). Strategic Planning for Public and Nonprofit Organizations. 3rd ED. San Francisco, California: Jossey-Bass Inc.

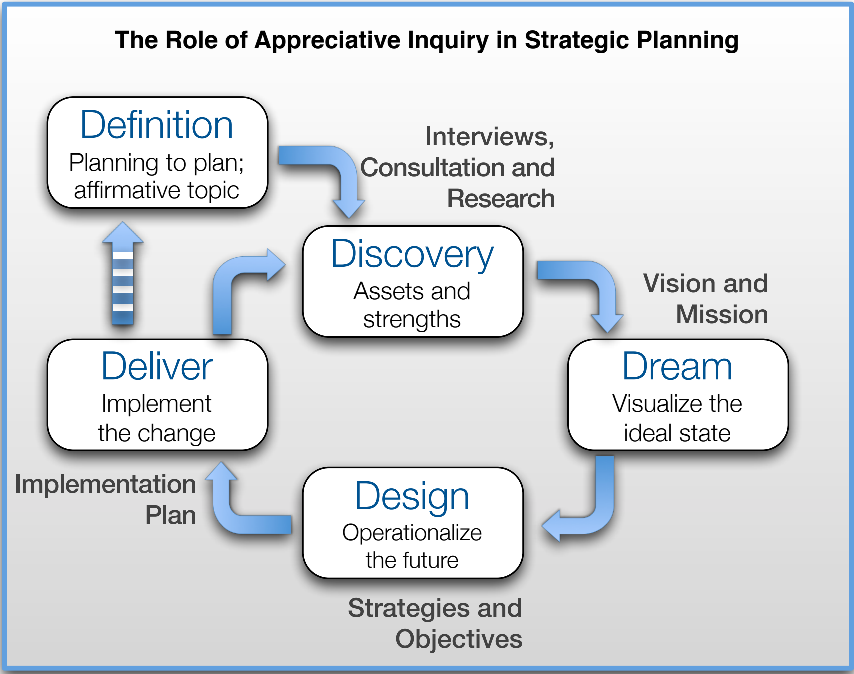
1.2 The Appreciative Inquiry Approach to Strategic Planning

Appreciative Inquiry (AI) is an assessment tool that identifies the current strengths of an organization and focuses on how those strengths can guide future successes.

> "AI is based on the simple assumption that every organization has something that works well and these strengths can be the starting point for creating positive change."[5]

The approach typically uses five phases (see Figure 1.2): Definition, Discovery, Dream, Design, and Delivery (sometimes called Destiny). In our strategic planning process, the Definition phase was conducted with the SPG to decide the nature and scope of the inquiries we would make on their behalf.

Figure 1.2: Adapting Appreciative Inquiry to Strategic Planning



In theory, the AI method does not explicitly account for organizational weaknesses, as does the typical strategic planning process with its SWOT[6] analysis. In practice however, most organizations prefer to do a modified SWOT analysis as part of the Definition Phase. This typically limits the discussion on weaknesses to the SPG and key stakeholders, so that broader consultation sessions need not focus on them. It contributes to the development of an

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[5] Cooperrider, D.L. Whitney, D., & Stavros, J.M. (2005). Appreciative Inquiry Handbook: The first in a series of AI workbooks for leaders of change. Crown Custom Publishing, Inc: Brunswick, OH.
[6] A SWOT analysis explores strengths, weaknesses, opportunities and threats in the context of one another, searching for ways in which strengths can overcome weaknesses or mitigate threats. In many cases, threats can become opportunities.

affirmative topic by identifying areas that can be complemented and expanded, and provides context for discussion.

We carried out the next three phases within the employee engagement sessions, asking them to consider a time when they were at their best (Discovery), idealize their THU of the future (Dream), and then develop provocative proposition statements to operationalize that future (Design). The final Delivery phase is where the plan is implemented, and is up to the organization to support, monitor and evaluate the plan as it moves forward.

As part of the Definition Phase, we consulted with the SPG and conducted a pre-session online survey for THU employees. Fifty-one employees (of 94) responded to the survey, an excellent rate that suggests THU members are engaged in the planning process.

1.3 The Strategic Planning Working Group

The SPG consists of twelve members, including:

- Randy Winters
- Carlyn McNamara
- Ryan Peters
- Janet Smale
- Theresa Nixon
- Krystal Oviatt
- Marlene Spruyt
- Ghislaine Julien
- Cam Clarke
- Rene Duval
- Gillian Souriol
- Kerry Schubert-Mackey

The SPG helped develop the affirmative topic that formed the basis of the AI method, and they also oversaw the strategic planning process. The ad hoc committee (Celine Butler, Amanda Mongeon, Dawn Olsen) helped review the surveys before they were released to their target groups.

1.4 Report Overview

This report includes the following components:

- A description of how stakeholders were involved in the planning process.
- An overview of information used to develop the affirmative topic (Definition), including internal and external environment analyses.
- A SOAR analysis –Strengths, Opportunities, Aspirations and Results– that corresponds with data collected during the Discovery and Dream Phases.
- A summary of the strategic themes distilled from the data that crystallizes the Dream phase into a more coherent framework.
- An implementation plan that provides guidance on how the THU can carry out the Deliver phase.

2.0 Stakeholder Engagement Strategy

2.1 Engagement Methods

In undertaking this strategic planning process, several methods of stakeholder engagement were necessary. The SPG identified employees, the general public, and health services organizations as key stakeholder groups, each of which required a different approach to capture relevant and important feedback. We encouraged stakeholder engagement by advertising and promoting the process through a variety of channels:

1. We developed and launched two websites specifically for this project, one English and the other French, at www.thu.clearlogic.ca and www.thufr.clearlogic.ca respectively. The links were then distributed to staff and partners. The site was also accessible from the front page of the Timiskaming Health Unit website.
2. The THU's communications department handled newspaper and radio ads.
3. SPG members invited people from their own networks to the public consultations.
4. We customized online surveys for three different stakeholder groups.

2.2 Sources of Input

2.2.1 Online surveys

We developed a purpose-specific survey to collect exploratory data from employees that could be used in defining the topic. The employee survey opened December 10, 2011 and remained active for approximately one month. 80 people began the survey and 51 completed it.

We developed a separate survey for THU clients, partners and stakeholders in the community at large. French and English versions of the survey were launched March 7, 2012 and remained open for two weeks. The survey collected 87 responses, although 21 respondents chose not to answer all of the questions.

The THU was able to gather input from stakeholders throughout the region using relatively inexpensive yet accessible online surveys.

Finally, we created a third survey to collect specific data from the regional Family Health Teams and long-term care facilities. The survey was launched in early April and remained open for two weeks, collecting 17 responses, eight of which were complete.

2.2.2 Employee summits

We held two employee summits for THU staff members. The first was on February 1st in Temiskaming Shores, and attracted 44 participants. The second was in Kirkland Lake on February 16th, with 24 participants. For both sessions, we used the adapted AI method described above. The process involved engaging employees in positive reflections of their past and hopeful anticipations of their future.

THU staff in Temiskaming Shores participated enthusiastically in this staff summit, which used the Appreciative Inquiry approach to determine priorities.

2.2.3 Stakeholder interviews

Between February and April, the consulting team interviewed a range of stakeholders in one-on-one settings. The SPG provided guidance in developing a list of interviewees. They included representatives from the following organizations (see Appendix A):

- OPP, Temiskaming Shores
- Centre de Santé Communautaire
- Early Years Centre
- Temiskaming Hospital
- Englehart and District Hospital
- Canadian Mental Health Association
- Kirkland & District Hospital
- Community Care Access Center
- District of Timiskaming Social Services Administration Board
- Timiskaming Brighter Futures
- Timiskaming Child & Family Services
- DSBONE
- Northern Catholic District School Board
- Conseil scolaire catholique de district des Grandes Rivières
- One Kids' Place

2.2.4 Public consultation sessions

As per the THU's mandate to solicit broad public input in establishing strategic directions, we held three public consultation sessions. We used engagement methods adapted from the ToP (Technology of Participation) facilitation model. Participants combined brainstorming activities with reflection, exploration, and group decision-making techniques. The first was in Kirkland Lake on March 5th, with 3 participants. The session held March 6 in Temiskaming Shores attracted 3 participants. Also on March 6 a session was held in Earlton that attracted no participants.

3.0 SWOT Analysis and Environmental Scan

3.1 SWOT Analysis Summary

This SWOT analysis (Figure 3.1) summarizes strengths, weaknesses, opportunities and threats for the THU. It combines input from the various consultation sessions and suggestions from the SPG, with the consulting team's research and comparative analyses of the organization's internal and external environments. Note that strengths and weaknesses are generally considered within the organization's control. Opportunities and threats are generated from the environmental analysis. They are considered external to the organization.

Figure 3.1: SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
1. External communication and promotion of programs. 2. Experts at data gathering and providing info to stakeholders. 3. Capacity/skills building, resource sharing, e.g. One Kids Place. 4. Respect/legitimacy because of expertise, leadership, relationships. 5. Good customer service to many client groups.	1. Some programs duplicative of services provided by other organizations. 2. Poor relationship with some existing partners. 3. Poor customer service for some clients e.g. Francophone, Aboriginal. 4. Challenges working within union environment. 5. Lack of direct management guidance in most offices. 6. Poor internal communication between departments, offices, and programs. 7. Lack of strong HR management to ensure staff are trained, motivated.	1. Changing/emerging demographics (seniors, Aboriginals, youth, etc.). 2. Reduce service duplication. 3. Gaps/needs assessments for priority and at risk populations, e.g. well seniors, well workers, etc. 4. Internet and social media usage. 5. Continuing need for public awareness of Social Determinants of Health (SDOH).	1. Area struggles with attracting new, qualified people. 2. Outside organizations' activities can have negative implications for THU mandate/budget. 3. Funding and accountability pressures. 4. Integration/ amalgamation of health organizations may occur under terms not conducive to THU.

We elaborate on each element in Figure 3.1 in the following section by describing the perspectives of the four major stakeholder groups: the general public, partner organizations (referred to as "Stakeholders/Partners"), employees, and Family Health Team members.

3.2 Strengths

3.2.1 External communication and program promotion

General Public: Results from surveys of the general public suggest that the THU does a good job of promoting its services. Levels of awareness for each of the thirteen programs the THU offers ranged from 85% (Dental services) to 100% (Flu shots). The public zeroed in on the promotion of healthy, active lifestyles as the THU's top priority (54%), while no other service ranked above 18%.

Respondents were asked to identify preferred communications vehicles for health information. The top three choices were editorial stories in local media, paid advertisements, and an e-mailed or on-line newsletter. The least popular methods of getting health information from the THU were in-person visits, telephone calls and social media such as Facebook.

Stakeholders/Partners: Community partners believe the THU has communicated its mandate well. Sample comments include:

- "Smoking cessation promotion is an example of good media use by THU"
- "THU good at advertising: public knows what services are offered"
- "Good promotion in radio and media"
- "Well established through use of media"

Employee Perspectives: Staff members are well-informed about the various programs the THU offers, even those services outside their own department. They take pride in the level of health communication and promotion the organization has established in the community. A sampling of typical comments follows:

- "Making the community aware of services through advertising"
- "Use of the media for program promotions is well done"
- "Visibility: residents know the health unit a lot more here than other towns"
- "Lots of visibility in the community both face to face, and through the media"

Family Health Teams: In general, the Family Health Teams are well-informed about the services at the THU. For all services except the dental program, seven out of eight respondents (88%) said they were aware of each service. Six out of eight (75%) were aware of the dental program.

3.2.2 Experts at data gathering and providing info to stakeholders

General Public: Most members of the community at large perceive the THU as trusted health experts. Fifty-seven percent of respondents said the THU offers valuable expertise to community, and 25% have actually called or visited the THU for health information. Some of the participant remarks included:

- “Works hard to keep our statistics for immunizations up to date”
- “Would like to have even more education done through schools for sexual choices, mental health awareness, drug awareness, and counseling availability”

Stakeholders/Partners: The THU has done an excellent job of building collaborative relationships with community partners. Such relationships build capacity in the community and help the THU to extend its resources in the pursuit of its mandate. Comments from the interviews include:

- “THU is a great partner for pre and post-natal info”
- “Communicate population needs and data”
- “Schools see them as experts and look to THU for information”
- “Share epidemiologist stats and communicate population health needs/data”

Employees: THU staff are proud of their reputation and role in the community as not only experts, but also leaders in health education and management. They are also committed to sharing information and knowledge with their partners. Excerpts from the surveys include:

- “No other agency looks at broad public health, the epidemiologist”
- “Up to date on issues, research, approaches affecting local catchment area”
- “Educate our partners about the differences in health and healthcare, and how to examine to get to the root of the problem”

Family Health Team: Respondents from this sector believe that the THU plays an important leadership and coordination role in the community, as exemplified in this comment:

- “Continue as they have been in coordinating meetings, surveys, etc. throughout the communities.”

3.2.3 Capacity/skills building, resource sharing

General Public: Community members recognize the role that the THU plays in health service capacity building. They suggest that the THU not only has front-line expertise, but also strategic and leadership skills that can be used to better coordinate regional health care services and promotion, while reducing duplication and administrative costs.

Stakeholder Interviews: THU partners also see a greater coordination role for the organization, as opposed to one that is always at the front line. This may be interpreted as an indication of the respect that partners and other stakeholders have for the THU’s capacity-building skills. Selected comments from the interviews include:

- “THU role is to bring community partners together: coordinate, not always lead”
- “THU voluntarily transferred staff to increase integration of services for clients; staff very supportive of move to One Kids Place”
- “Good they transferred speech pathology out”
- “Could be more efficient if we could pool resources/staff”

Employees: Staff members are also interested in creating more opportunities to extend health education and information through partner organizations. Some of their suggestions follow:

- "Information and education to schools - more involvement with the school boards"
- "Build working local partnerships to share information, resources & maximize THU reach of service"
- "Evidence of our success: requests from other HU's to use our resources"

Family Health Team. Among the respondents who completed this question, 5 out of 7 said the quality of THU resources was good or very good. Comments and suggestions included:

- "Receive vaccines and assistants from THU; assistance and signage re: flu outbreaks"
- "Allow staff in the various disciplines, e.g. dietician, to go to various other organizations to provide education sessions or make a presentation to a specific group of individuals, i.e. diabetic patients."

3.3 Weaknesses

3.3.1 Some programs duplicate services from other organizations

General Public: As noted in the Communication and Program Promotion section under Strengths, respondents from the general public identify the THU very closely with health promotion and believe that to be its top priority. Interestingly, while 82% believe the THU's services benefit the community, only 45% said the THU responds to community needs. This suggests two things: first, that this audience perceives unmet needs in community health services, and second, that while the general public appreciates THU's current roster of services, these may not be the services that the community really wants. The stakeholder and employee comments shed more light on this issue.

Stakeholder Interviews:
Many stakeholders complimented the THU's forward-thinking and innovative program approaches. There was a tendency among respondents to mention perceived service overlaps, and a desire to see the THU provide only those services not already addressed by other health providers. This can be interpreted as a vote of confidence in the THU. The public believes that based on its expertise and reputation, the THU can effectively venture into new program areas in which other providers lack capacity. Sample comments included:

- "They wear too many hats"
- "Choice can be a good thing. But we hear more confusion from clients"
- "Stop providing programs (e.g. mental health) that are already provided by another agency. Use those health care dollars for other programs that are not locally provided"

Employees: Employees echoed the comments of the partners and stakeholders we interviewed. When asked what opportunities the organization might exploit, participants offered the following comments:

- "How to change the trend of being everything to all people and focus on what we do really well"
- "Unlimited opportunities but limited capacity (time, human resources)"
- "Where to focus -- all partners have different core programs -- how can we all work together to achieve bigger and better things"
- "Understanding of who we are, and what we do - misunderstanding of THU and services offered - could result in missed opportunities or negative community response"

3.3.2 Relationships with some partners could improve

General Public: Members of the public tend to view the THU as a leader and coordinator as well as a provider of health services. They commented on the potential for the THU to take a greater role in the coordination aspects of public health service delivery.

- "More partnerships with various agencies in the community for greater outreach."
- "More services offered within local child/family programs (eg. OEYC) so that it is easily accessed and where family already attends programs."

Stakeholder Interviews: Many of the stakeholders echoed the comments of the general public with respect to the THU's coordination role. The results tend to show a preference for the THU to put more focus on coordinating services, and less on delivery. While many complimented the THU on recent improvements in efforts to build partnerships, others noted that there is work to do in building the relationships that underlie effective collaborations.

- "Some staff at partner agencies unwilling to work collaboratively with THU due to bad history"
- "Health unit personality can clash with other organizations"
- "Need a joint vision. Silo approach for decades"
- "There is competiveness as similar services may be provided and this causes rivalry, lack of communication, and inappropriate referrals"
- "Not an agency that partners well, very silo driven"

Employees: Staff members are aware of the opportunities for working with other organizations, and most would welcome more partnerships. Most employees recognize the importance of building inter-agency relationships based on shared goals, trust and communication. Some mentioned the importance of having strategies to help facilitate relationship-building and cooperative efforts with other organizations.

- "Improvement in our reputation with partners in the district"
- "Personal relationship is key; not enough personal relationship building between THU and partners"

- "More collaboration with external partners"
- "Partnership - THU should focus more on developing partnerships to ensure broadest reach possible"
- "Past partnerships with THU have not been solid due to inconsistent funding - hard to get partners back"

3.3.3 Poor customer service for some clients, e.g. Francophone, Aboriginal

General Public: Overall, respondents from the general public were positive about the services the THU offers. Comments about service delivery tended to be around language, for example:

- Only 20% of respondents said the THU provides culturally and linguistically appropriate programming.
- Just under 8% of respondents like to receive health information in French.

Stakeholder Interviews: Participants in the one-on-one interviews had more specific customer service feedback, much of it centred around personal communication styles.

- "THU can be invasive, intrusive nature for participants; they avoid health unit programs because of approach, feel harassed by THU staff"
- "Style of delivery can be a turn off (eg. "you must do this" and "you have to"); authoritative delivery"
- "Perception that you need to be a 'normal' family to access THU services"
- "THU not able to service mental health Francophone"
- "Recognize population has minority population and must allocate time, space for minorities. Translation not enough (does not equate with service)"

Employees: Employees echoed the language concerns raised by members of the general public. They recognize opportunities to improve customer service by delivering services in both official languages and in a context that is more sensitive to Aboriginal culture.

- "Cultural and language differences (e.g. PPMD program and Aboriginal and Francophone communities) - lack of trust in qualifications and delivery of service"
- "Awareness of services (needs of Francophones and Aboriginals are not always adequately met - need more culture-sensitive training)"
- "I know English schools are receiving services, but French schools in the south end not"
- "Increasing bilingual programs (French schools, French prenatal classes)"

Family Health Team: Family health team members' comments on service quality were based on communication, particularly related to follow-up and responses to requests for information.

- "I have requested wellness clinics for my staff several with no follow through - never done"

- "Offer more community education - I've requested education for our residents, families and staff re: flu vaccination, but none provided as no one returned my call."

3.3.4 Challenges working within union environment

General Public: Some participants noted that managers must sometimes walk a fine line between respecting their employees' collective bargaining rights and offering the best health services possible to clients. As one respondent remarked, "I realize there is probably a union issue at play, but not having someone available during the lunch hour is terribly inconvenient."

Employees: Staff members also recognize this challenge, and suggested that managers and supervisors might benefit from professional development in this area:

- "Provide training to management on how to better manage in a union environment"
- "Motivating employees when there is no way to give bonuses or other incentives"
- "Can't reprimand or dismiss incompetent staff (union environment)"
- "Challenge to move us forward as a team in the union context, which is divisive and can be limiting"

3.3.5 Lack of direct management guidance in most offices

General Public: One survey respondent suggested that outlying offices would benefit from a greater management presence so that the needs of those communities are better communicated to the main office. "Admin is too Temiskaming Shores centric and does not reflect an understanding of my community."

Employees: THU staff expressed a desire for more management involvement at outlying offices. Meaningful management presence can have a tremendous positive impact on employee motivation, development, performance and commitment. Selected comments include:

- "Management is only in one office - they can't supervise everyone all the time"
- "How do you keep track of what is happening in other offices with no managers there?"
- "Geographical separation from staff: this can create barriers to communication and maybe even perceived favoritism when working with the NL team"
- "How do you keep all staff engaged when they are spread throughout the district?"
- "Difficult to be tuned into the office dynamics to address staff conflict and challenges"
- "Provide appropriate supervision of staff with the aim to improve mentoring, identifying strengths and weaknesses, thereby establishing which programs staff can excel in and are suited to and make the best use of human resources"

3.3.6 Poor internal communication between departments, offices, programs

Employees: Staff members would like to see better communication and information sharing throughout the organization.

- "Communications within organization not always good, easy to forget to keep others up to date. It's normal to hear news from radio instead of management"
- "Teams work in silos"
- "Lack of interdepartmental collaboration/support/information-sharing"
- "Not enough communication between programs - not knowing what each other does or services that are offered"
- "Geographic challenges and a sense of isolation between offices."

3.3.7 Lack of strong HR management to ensure staff are trained, motivated

General Public: Although this particular theme is generally an internal issue, some members of the general public sensed that there are workplace cultural issues to be addressed. Comments included:

- "The hiring and interview process needs to be fairer. Good applicants are being overlooked"
- "Continue to work on the morale of your staff"

Stakeholder Interviews: Partner organizations perceive that recent turnover at the THU is affecting the ability to build and maintain good working relationships. This may or may not be a fair assessment, and time will determine whether or not these perceptions are accurate. That being said, the comments generated by this group suggest a need for a comprehensive human resources strategy that addresses succession, workforce planning, mentoring and professional development. Selected remarks include:

- "High turnover of SW position (THU partner with hospital; high stress position, high workload contributor to turnover"
- "Still need to have discussion and trust to build awareness due to high turnover at THU"
- "Managers coming in without historical knowledge"

Employees: Staff at the THU also expressed concern about the recent turnover at the organization. Changes in staff –particularly at the senior management level– can result in an atmosphere of uncertainty and anxiety. Examples of respondent feedback include:

- "Important to maintain a commitment to a highly qualified management team"
- "Staff morale, continue to build a positive work environment"
- "Increasing community's image of THU- high staff turnover makes community partnerships difficult- takes awhile to build relationships"
- "Not having performance appraisals creates an environment where employee development is not encouraged or valued"

- "Greater commitment to professional standards of practice and hiring appropriate staff based on qualifications as well as desire to work in public health"
- "There is no overall plan of professional development and training within program areas, which gives a hit/miss approach"

3.4 Opportunities

3.4.1 Changing/emerging demographics, e.g. seniors, Aboriginals, youth, etc.

Changes in demographics call for a review of health services to ensure that they address the needs of each emerging or changing sector. For example, the growth in the Aboriginal population generates opportunities for new programs that are culturally attuned to the Aboriginal worldview and aligned with the particular health priorities of this group. Often, such opportunities can generate new funding arrangements, partnerships and access to additional resources.

Stakeholder Interviews: THU partners and community organizations suggested several emerging trends, including:

- "Recognize that the regional population has a minority population and must allocate time, space for minorities. Translation not enough (does not equate with service)"
- "Increasingly older population stays at home so how do we reach them? Radio, church groups, and active service clubs"
- "THU could use cultural organizations to access respective populations"

Employees: Employees noted the following trends:

- "A shift in our population curve, e.g. an aging population interested in maintaining wellness. How do we support healthy communities that benefit all ages?"
- "Aging population with very few young people moving home"
- "Aging population, more flu outbreaks, more chronic disease"
- "Corporatization and globalization contributing to a declining middle class, eroding incomes and population wanting to pay taxes for public services"

3.4.2 Reduce service duplication

General Public: There is a perception by some of the respondents from the community-at-large that the THU is duplicating services available from other providers. For example:

- "Most services should be transferred to other health care providers to avoid duplication and save tax dollars."
- "The THU is a duplication of services provided by other healthcare providers or offers services that could be provided as well from other agencies"
- "Stop providing programs--mental health--that are already provided by another agency; Use those health care dollars for other programs that are not locally provided"

Stakeholder Interviews: Some of the THU's partners also identified duplication of service as an issue that detracts from the THU's reputation as a legitimate and community-building organization. Some of the comments included:

- "Would like to see consolidation of mental health services"
- "Fragmented services results in confusion"
- "Duplication in initiatives"
- "Could be more efficient if we could pool resources/staff"
- "Joint goal is to serve population but do so with partnerships"

Employees: Staff members see opportunities in streamlining existing programs and using the THU's skills and knowledge to hand off some of its current programs to partners who are already offering similar services, or who are positioned to do so.

- "We need to get a better handle on what partners are doing to minimize duplication of services & provide for needs of targeted populations"
- "Where to focus -- all partners have different core programs - how can we all work together to achieve bigger and better things"
- "Lack of collaborations among organizations with overlapping mandates - makes it more challenging to increase community capacity because you have several groups to reach instead of one network"
- "THU may have to offer more services or different services based on changing abilities of community partner organizations - need to be dynamic; Critically analyze services offered in community"

Family Health Team: Responses from this group focused on mental health and addiction services, but there was no consensus: For example, three respondents said the THU should expand mental health services and continue in leadership role, and three suggested it should hand off the service to a community partner. Similar confusion surrounded addictions programs.

- "Mental Health: is this service not provided by CMHA -- why do we have two agencies?"
- "Mental Health: is this a duplication or are you filling a gap in the community? Unsure"

3.4.3 Gaps/needs assessments for priority and at-risk populations

General Public: Comments from the community at large focused on improving the health of young people:

- "They should promote more active living for the young people in the area who are school age or preschool age. If we can get them more active and away from their screens it will have a lasting affect."
- "Target the teens smoking/drug issues"

Stakeholder Interviews: Partners and other organizations advocated study and planning to determine which at-risk groups were of highest priority:

- "Partner with Family Health Team to identify at risk groups"
- "Some very high risk population in rural/remote areas"

Employees: Staff members were also of the opinion that the THU would benefit from some needs assessment studies to inform the decisions around new programs and services:

- "Understand Timiskaming priority population profile & identify gap between current services & requirements of priority populations, identifying if certain regions have greater need"
- "Evaluate populations being served & determine if their needs are being met"
- "Recognize the different strengths and limitations of all communities"
- "Having timely, local information to feed decision-making & support planning for priority populations"
- "Effective Program and Operational Planning will help to plan programs that are most suitable for our communities and avoid creating further disparities"
- "Knowledge of the importance of evidence informed decision-making will help programs to meet the needs of the community"

Family Health Team: Respondents in this group identified specific priorities:

- "Sexual health: get into the schools starting at Grade 5/6 to provide the service -- bring it to the youth population as opposed to waiting for them to access it on their own"
- "Need for education to community re: mental illness awareness"
- "Go back to face-to-face well baby home visits with new moms. Doing an assessment over the telephone for post partum depression is not sufficient"
- "Falls prevention is a huge risk for the elder and education would be very beneficial to LTC home and elders in the community"

3.4.4 Internet and social media usage

General Public: Social media as a method of communication ranked very low on our community survey. That being said, this finding must be be weighed against the number of youth –the predominant users of social media– that responded to the survey (fewer than 5% were younger than 30 years old, and none were younger than 20).

Stakeholder Interviews: Members in this group believe there are many opportunities to communicate using social media.

- "Good media use and marketing, but should use social media"
- "Be proactive and raise level of awareness especially with young people (use facebook)"

Employees: Employees are strong advocates of integrating more technology into their service delivery processes. Suggestions included:

- "Using technology for communication with clients (email, facebook, etc.) to reach more people"
- "Innovative technology - using youtube, facebook, sms, social media to reach priority population"
- "Expansion of social media use - thinking outside the box for getting the message out"
- "Using technology for communication with clients - email, facebook, etc - reach more people"

3.4.5 Continuing need for public awareness of SDOH (Social Determinants Of Health)

Stakeholder Interviews: THU partners and other community organizations recognize the importance of increasing public awareness of factors that can impact their health. For example:

- "Youth/teens coming in with friends with mental health issues/drug abuse and getting younger (grade 7 and 8 and up); need ongoing info"
- "Be proactive and raise level of awareness especially with young people (use facebook)"

Employees: Staff members stressed prevention-oriented education as a means of improving overall health:

- "Trying to change social norms and beliefs of health"
- "Increase public awareness of the social determinants of health in order to change health beliefs and norms"
- "Educating the public to take better care of themselves health-wise"
- "SDOH - living in Northern Ontario, we generally have less access to many things, which would put people in Timiskaming at a higher risk of unhealthy lifestyles"
- "Use the SDOH lens in planning and implementing to ensure we are not contributing to making access more challenging for specific populations"

3.5 Threats

3.5.1 Area struggles with attracting new, qualified people

Employees and Stakeholder Interviews: Both groups noted the challenges associated with recruiting skilled people to the area. For example:

- "Limited pool of qualified staff and volunteers (including Board members)"
- "Lack of physicians and other professionals"
- "Finding and retaining qualified workers, especially Francophone"
- "Challenge to attract & retain educated professionals"

3.5.2 Outside organizations' activities can have negative implications for THU mandate/budget

Employees and Stakeholder Interviews: Both groups noted that THU operations were often impacted by the cascading effect of cuts or changes to other organizations operating in the health and social services sectors. For example:

- "Challenge in government mandates"
- "Managing the unknowns or constant changes from the ministry level. Accountabilities, funding, mandate, etc."
- "Gov't funding cuts to various agencies that may force agencies to look to other agencies to form partnerships."

3.5.3 Funding and accounting pressures

Employees: Austerity and fiscal restraint are often top-of-mind challenges for staff members, who commented:

- "Keeping and increasing our share of the health care dollar"
- "Sustainability - need to look well ahead to determine what can be sustainable, and how can we sustain services, partnerships etc. with limited dollars"
- "Funding changes, contract funding - changes priorities and program targets within THU when new funds are available for specific target population needs"
- "Fiscal tightening. To keep municipalities on board with funding schemes, it seems we need to continue (and build) our promotion of our agency"
- "Planning for two to three quarters prior to government approving budget"

3.5.4 Integration of health organizations may not be conducive to THU

Employees and Stakeholder Interviews: Recommendations for greater integration and amalgamation of health services have introduced a degree of anxiety and uncertainty around the THU's ongoing role. For example:

- "Concern for loss of identity if agency gets taken over by Timmins or North Bay health units"
- "Transitions in play: Health Unit could tie into the IT data to find pressure points/ help with planning and integration"
- "Integration with other agencies. Strong local partnership that THU has with them could be reduced if they were part of a larger organization"
- "Our position with the LHINS they need to consistently know of the good work being done"
- "More emphasis on promoting what we are doing well with the Ministries and LHIN"

3.6 Environmental Scan

An environmental scan examines factors that are external to the organization, but can have significant influence on its operations. Influential factors include people and demographics, the economy, politics and government, technology and geography.

3.6.1 People and demographics

The Timiskaming District is comprised of more than twenty municipalities and townships, including the communities of Temiskaming Shores, Kirkland Lake and Englehart, where the THU has offices. According to the results of the 2011 census, the total population of Timiskaming District is 32,634, with a reduction in population of 1.9% since 2006.[7] In the Timiskaming Health Unit area, 44% of the population is categorized as rural, compared to 15% in Ontario. The population density is 2.4 people per square kilometer.[8] Agencies that serve sparsely populated areas spread out over large regions face considerable challenges in providing the same level of service as those in more urban areas.

There are several cultural-linguistic and demographic sectors of significance to the THU's long-term planning initiatives. These include Francophones, Aboriginal people, seniors and youth. Each of these is profiled briefly in the following section.

Note that much of the statistical information available from Statistics Canada and other government agencies is not specific to the Timiskaming Health Unit area. Census districts for which data are available are often defined in terms of the Timiskaming District or Northeastern Ontario, both of which include communities outside the THU jurisdiction. That being said, it is reasonable to assume that statistics from these regions are a closer reflection of conditions in the THU region than are the statistics for the province as a whole.

Francophone Population

Nearly one quarter (24%) of Timiskaming District residents identify French as their mother tongue, compared to 4% in the rest of the province. One third are bilingual, as compared to the provincial bilingualism rate of 11%; three percent of the Timiskaming populace speaks only French.[9]

Ontario Francophones are more likely to have trades certification (11% versus the 9% provincial average) and less likely to have a university degree (28% versus 31%). They are also somewhat less likely to complete high school: 15.5% of Francophones have no certificate,

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[7] Statistics Canada. (2012). "Census Profile." Statistics Canada Catalogue. Released February 8, 2012. Accessed April 8, 2012 at statscan.gc.ca.

[8] Statistics Canada. (2011). "Health Profile, October 2011." Statistics Canada Catalogue. Released October 25, 2011. Accessed April 9, 2012 at statscan.gc.ca.

[9] Statistics Canada. (2007). "2006 Community Profiles." Statistics Canada Catalogue. Released March 13, 2007. Accessed April 25, 2012.

degree or diploma, compared to the provincial average of 13.6%. Figures specific to the Timiskaming Health Unit region are not available. However, statistics for the greater Northeastern Ontario region indicate that Francophones are lagging behind their provincial counterparts. Only 10% of Northeastern Ontario Francophones have university degrees, less than one third of the Ontario average.[10]

Regardless of the type of income considered, Francophones in Northeastern Ontario earned less ($33,796) compared to Francophones in the other regions. The average employment income for Francophones in Ontario in 2006 was $39,976. At the low end of the income scale however, Northeastern Francophones fare slightly better. While one in ten Ontario Francophones lived below the low-income cut-off in 2006, the proportion in Northeastern Ontario is 7.1%.[11] Among the senior Francophone population, 1.3% fall below the cut-off, compared to 2.1% in Ontario.[12]

Aboriginal People

Census documentation from 2006 indicates that 5.6% of the population in the Timiskaming Health Unit region is Aboriginal; the provincial proportion is 2%.[13] According to statistics for the entire Timiskaming District, the majority identify as Metis (62%), and 36% as North American Indian.[14]

Ontario's Aboriginal population is relatively young, as their birth rate is two times the rate of the general population. People of Aboriginal descent score lower on all educational attainment indicators, and are more likely to face long stretches of unemployment. The average personal income for Aboriginal people in Ontario has increased by 6%, or $1,586, from 2001 to 2006 but it remains significantly lower than average at $38,318.[15] Figures specific to the Timiskaming Health Unit area are not available.

In general, Aboriginal people experience higher rates of smoking, alcohol and substance abuse, and bear a disproportionate burden of many infectious diseases. The prevalence of self-reported chronic conditions, injury rates and mental health issues within Ontario's Aboriginal population is higher than in those of non-native descent. The most common cause of death among the Aboriginal population is motor vehicle accidents.[16]

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[10] Statistics Canada (2006) Census of Population.
[11] Ibid.
[12] Ibid.
[13] Statistics Canada. (2011). “Health Profile.”
[14] Statistics Canada. (2008). “2006 Aboriginal Population Profile.” Statistics Canada Catalogue. Released January 15, 2008. Accessed April 24, 2012 at statscan.gc.ca.
[15] Ministry of Aboriginal Affairs. (2012). “Aboriginal Living Conditions.” Accessed April 10, 2012 at aboriginalaffairs.gov.on.ca/english/services/datasheets/living.asp
[16] Shah, Chandrakant P. and Fara Ramji. (2005). “Health Status Report of Aboriginal People in Ontario.” Department of Public Health Sciences, Toronto. Accessed April 8, 2012 at tinyurl.com/6nmk4mp.

Aboriginal households rely more on government transfers, which comprise 24% of their total income.[17]

Seniors

18% of the Timiskaming District population is 65 years of age or older, with a median age of 44.7 years. In contrast, the Ontario population is comprised of 14% seniors, and the median age is 39.[18] In the Timiskaming Health Unit area, 19% of the population is 65 years of age or older.[19]

Within the Timiskaming Health Unit area, there were 374 hospitalizations for hip fractures per 100,000 population compared to 437 per 100,000 in Ontario. It is unknown as to whether this reflects a significant difference in health across the two groups, or the reduced access to non-critical surgical procedures that Northerners face.[20]

Youth

In Timiskaming, 15.9% of the population is under the age of fifteen compared to 13.6% in the rest of the province.[21] However, youth outmigration remains a threat. The number of youth aged 13-24 decreased from 2001 to 2006 by 5.7% compared to an increase of 9.3% in Ontario.[22]

14.2% of children 17 years of age and under in the Timiskaming Health Unit region live in low-income families compared to 17.9% in the rest of the province.[23]

3.6.2 Health challenges

Northern Ontario faces a range of health challenges, many of which are a function of its relatively rural and remote nature. These challenges include:[24]

- Limited access to non-acute and primary care services leads to higher hospitalization rates.
- Less access to public health services and education, impacting health promotion and wellness initiatives.

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[17] Statistics Canada. (2008). "2006 Aboriginal Population Profile."
[18] Statistics Canada. (2007). "2006 Community Profiles."
[19] Statistics Canada. (2011). "Health Profile."
[20] Ibid.
[21] Statistics Canada. (2007). "2006 Community Profiles.".
[22] The Ontario Trillium Foundation. (2008). "Your Community in Profile: Muskoka, Nipissing, Parry Sound, Timiskaming," 17. Available at the Ontario Trillium Foundation, Toronto.
[23] Statistics Canada. (2007). "2006 Community Profiles."
[24] Ministry of Health and Long-term Care (2011) "Rural and Northern Health Care Framework/Plan," Retrieved April 10, 2012 at http://health.gov.on.ca/en/public/programs/ruralnorthern/report.aspx

- Limited availability of cultural and linguistically appropriate services (e.g. Aboriginal, Francophone), which impacts access and outcomes.
- Scarcity of resources (e.g. health human resources, infrastructures, technologies, etc.).
- Difficulty in recruiting health care professionals.
- Demand for rural health providers to take on more responsibility than required in urban areas.
- Limited capacity to respond to health care challenges, engage in planning, pursue special grant opportunities, raise capital to support local share requirements for new infrastructure, or to support ongoing capital equipment renewal.
- Political challenges in implementing strategies to improve access, which may result in sub-optimal service delivery models and access.
- Limited coordination and clarity on the roles, accountabilities, funding and service models for health care services across federal, provincial and aboriginal governments.
- Varying alignment and success of planning and engagement by LHINs with the aboriginal population.
- Limited availability of non-urgent transportation in some northern, remote and rural areas, which impacts the access to physicians clinics, educational institutions, employment options, and other services.
- Lack of rural perspective applied in planning at the provincial or LHIN levels, and the need for increased flexibility at the local level to drive innovations.
- The boom-and-bust economic cycles and single-industry dependency in many rural and northern communities impacts the economic contributors to health status.
- Limited sharing of health records and information across professionals within the system.

These issues are ultimately reflected in lower levels of health and wellbeing for residents of northern Ontario. For example, individuals in the Timiskaming Health Unit area score lower on many health indicators than their counterparts in other parts of the province (see Figure 3.2).

Furthermore, the rate of hospitalization for an injury in the Timiskaming District is 667 per 100,000, versus 406 per 100,000 in Ontario. Reported rates of hospitalization for self-injury are 109 per 100,000 compared to 58 in Ontario.[25]

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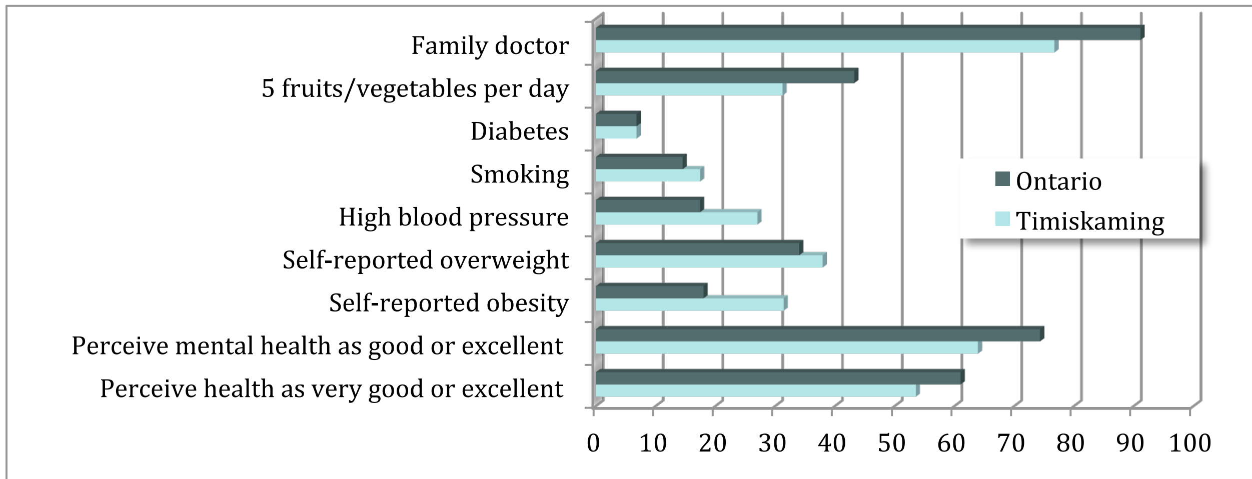
[25] Ibid.

Figure 3.2: Comparison of Self-Reported Health Indicators: Timiskaming vs. Ontario[26]



3.6.3 Socioeconomic factors

The Timiskaming District tends to score lower than other regions on many of the socio-economic factors that contribute to overall health.

Education

In Timiskaming, 65% of the population 15 years of age or older have at least a high school diploma or equivalent, versus 78% in Ontario. Just over 42% have some kind of post-secondary degree, diploma or certificate, versus 51% across the province. Less than 8% of the Timiskaming population has a university certificate, degree or diploma, versus 20% in rest of Ontario.[27] The lack of a University within the region is a contributing factor to the lower-than-average university graduation rates.

Employment

The overall unemployment rate in the Timiskaming District is 8% compared to Ontario at 6%.[28] Within the Timiskaming district, Cobalt and Englehart have reported unemployment levels above 10%.[29] Of this, the majority of unemployed individuals are between 15 and 24 years old, both in Timiskaming and in Ontario as a whole. 8% of people that are part of the labour force in Timiskaming are unemployed, compared to 6% in Ontario.[30] The top five industries in Timiskaming are retail; healthcare and social assistance; construction; accommodation and food services; and manufacturing.[31]

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[26] Statistics Canada. (2011). "Health Profile."
[27] Statistics Canada (2012). "2006 Community Profiles."
[28] Ibid.
[29] Palmer, Lise (2011) ibid, 15.
[30] Statistics Canada (2012). "2006 Community Profiles."
[31] Ibid.

Income

Average annual gross income in Timiskaming is $29,825 compared to Ontario at $38,099. Average annual gross household income in Timiskaming is $54,832 compared to Ontario at $77,967.[32] Also of note, in Timiskaming, nearly 18% of each resident's income comes from government transfers, versus 10% in the rest of Ontario.[33]

Housing

78.6% of private dwellings in Timiskaming are single-detached houses compared to 56.1% in the rest of Ontario. Timiskaming's housing inventory is older, in general, than the provincial average. Just over 87% of private dwellings were built prior to 1986 compared to 69% in Ontario. About 11% of total private occupied dwellings in Timiskaming require major repairs as opposed to 7% in Ontario.[34] Older homes generally require more repairs and updates, and single detached dwellings require the owner to pay utility bills. Long and cold winters in Northern Ontario, combined with older homes that are less energy efficient, cause higher housing costs for homeowners. These facts shed light on the living circumstances of low-income families and seniors who live alone, as lack of resources to bring homes up to standards of repair and energy efficiency is a barrier.

3.6.4 Technology

Technology is an influential environmental factor with great promise in terms of operational efficiencies, accessibility and communication. Ontario's recently released *Action Plan For Health Care*[35] specifically addresses the potential of technological solutions, which have resulted in productivity gains and effectiveness. Recent advances have resulted in reduced wait times, better diagnostic tools, virtual health initiatives that are eliminating the barrier of distance, and electronic health records that are enabling a more patient-centred system (p.6).

Several health organizations are already collecting and sharing best practices through on-line, searchable databases and sites. For example, the Public Health Agency of Canada offers a Canadian Best Practices Portal[36] with resources and interventions for health agencies. The site also offers a chat function for practitioners, interactive program planners for staff, and links to evidence-informed policies and programs.

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[32] The Ontario Trillium Foundation. (2010). "Your Community in Profile: Muskoka, Nippissing, Parry Sound, Timiskaming," 49.
[33] Statistics Canada. (2007). "2006 Community Profiles," Ibid.
[34] Ibid.
[35] Ministry of Health. (2012). "Ontario's Action Plan For Health Care: Better patient care through better value from our health care dollars." Available at
http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/ rep_ healthychange.pdf.
[36] Available at http://cbpp-pcpe.phac-aspc.gc.ca/.

Key barriers to implementation include:

- The expense associated with investments in infrastructure, equipment, applications and training.
- Ongoing lack of high-speed internet access in remote areas of the district.

Social Media

Social media, or new media, refers to an online communication tools that encourage interaction between the creator and the user of content. Popular examples of social media include Facebook, Youtube, Twitter and Linkedin.

In the U.S., 60% of state health departments are using some form of social media, and 80% of physicians are doing the same. A recent study found that one-third of adults now access health information using social media.[37] In Canada, use of social media by healthcare providers quadrupled during 2011 alone.[38]

Individuals use the internet to find and rank healthcare providers, discuss health experiences, and get information that they could not get as quickly or easily by booking an appointment. The Peel Region Public Health Unit and the US National Cancer Institute are becoming role models for how health organizations can use social media to promote programs, provide health information, and reach out to consumers of health services.[39]

A survey conducted in the U.S. asked respondents to rank answers on a scale of one to five with five being the highest. The results showed that 82.3% of respondents who used social media to get health information trusted that information at three or greater and 78.8% ranked three or greater on the likelihood that information would influence their health decisions.[40]

There are many benefits of using social media, including:

- Faster response times and greater potential frequency of interactions.
- Options to meet outside the typical meeting setting at stakeholders' convenience.
- Low-cost and low-maintenance knowledge sharing.
- Ability to reach a wider network of groups and individuals.
- Greater emphasis on the social aspects of public health.[41]

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[37] Society for Public Health Education. (2012). "Use of Social Media in Health Promotion: Purposes, Key Performance Indicators, and Evaluation Metrics." *Health Promotion Practice*. Accessed on April 11, 2012. Available at http://hpp.sagepub.com/.

[38] The Change Foundation. (2011). "Using Social Media to Improve Healthcare Quality." *The Change Foundation*. Accessed on April 9, 2012. Available at http://ebrary.com/.

[39] Schein, Rebecca. "Literature Review on Effectiveness of the Use of Social Media: A Report for Peel Public Health," (2010). Peel Public Health. Accessed on April 8, 2012. Available at http://ebrary.com/.

[40] The Change Foundation (2011), Ibid.

[41] "Social Media Overview" (2010). *Ontario Health Promotion E-Bulletin*. Health Nexus. Accessed on April 10, 2012. Available at http://www.ohpe.ca/node/11601.

The barriers to using social media in healthcare include confidentiality of patient information, questions around the validity of source data and a lack of best practice research to support its use.[42] That being said, social media applications present an interesting opportunity for the THU to leverage its expert status while increasing health promotion channels.

3.6.5 Political factors

Ontario's Action Plan For Health Care

The Ontario Action Plan for Health Care[43] was released in February 2012. The plan outlines how health care will be transformed to provide better patient access, higher quality care, and more value to reduce rising health costs as Ontario's population ages. This document will have a significant influence on the government's funding allocations to health care providers across the province. There are two key themes in this plan: The first is "doing more with less", by achieving efficiencies through better management, coordination and technology. The second is on long-term planning and prevention strategies.

The Action Plan prioritizes disease prevention and ongoing wellness by promoting healthy habits, supporting lifestyle changes and better managing chronic conditions. Relative to the Health Unit's mandate, the plan identifies the need to:

- Develop a childhood obesity strategy.
- Expand efforts to achieve a 'Smokefree Ontario.'
- Engage health care leaders.
- Promote integration between mental health care providers and others in the Local Health Integration Networks to establish a more patient-focused and health-outcome oriented process.

Refer to Appendix B for a selection of relevant highlights from the Action Plan.

Ontario Government Budget, 2012

The Ontario 2012 budget was released March 27, 2012. Public health in particular is not mentioned, although health in general and education are identified as priorities. The Government plans to limit spending through wage freezes and a reduction of the Public Service. Several social determinants of health are addressed in the budget:

- The implementation of full-time junior kindergarten province-wide by 2014.
- The implementation of the Ontario Health Care Plan to focus on health promotion, reducing obesity and smoking rates.
- A review of social assistance.
- An increase in fines for tobacco enforcement.
- Integration of Family Health Teams into the LHIN.

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[42] The Change Foundation (2011), Ibid.
[43] Ministry of Health (February 2012) ibid.

- Emphasizing home care and healthy, safe ageing.

There are no specific line items in the budget for health promotion or disease prevention. Refer to Appendix C for a selection of health-oriented highlights from the Ontario Budget.

The Drummond Report

Economist Don Drummond's report on reforming Ontario's public services includes 362 recommended reforms to balance the books by 2018. The report was released February 15, 2012. Drummond recommended several changes to health care in Ontario including a cap on health care spending at 2.5% each year to 2017-2018, increasing the use of home-based care and several recommendations related specifically to Health Units.

The Report seems to have informed the development of both Ontario's Health Care Plan and the 2012 budget, although there are some notable differences specific to Health Units. For example, Drummond recommends uploading Health Units to the province and integrating them under the LHIN, although neither of these recommendations was addressed in the budget or the health care plan.

Drummond recommended the following:

- More emphasis on health promotion and disease prevention (current core mandate of health units) to keep people out of (expensive) hospitals.
- Integrate Health Units with LHIN.
- Upload Health Units to the Province, and remove from municipal jurisdiction.
- Improve coordination in health system.
- Improve capacity to take a systemic approach, and collaborate with partners to improve health promotion and health outcomes.

Refer to Appendix D for a more detailed, health-related excerpt from the Drummond Report.

4.0 The Dream Phase

The SOAR model (Strengths, Opportunities, Aspirations and Results) evolved as part of the AI process and replaces the traditional SWOT approach.

A SOAR analysis focuses on the organization and its future, rather than on perceived threats and weaknesses.

It asks the following questions:

- What are our greatest strengths?
- What are our best opportunities?
- What is our preferred future? These aspirational concepts encourage participants to push their understanding of what is possible. The aspirations then evolve into strategic directions.
- What are the measurable results that will tell us we've achieved our preferred future?

THU employees engaged in lively discussion and respectful debates about the organization's future directions during the Dream phase.

Participants kept an open mind and contributed enthusiastically to the consultation process. The groups brainstormed a number of ideas that they ultimately developed into 16 aspirational statements, each of which was linked to opportunities and strengths.

We evaluated the aspirations in the context of the session from which they came, then examined them relative to the data collected in the environmental scan. We then looked for common themes in the aspirations to see if the original 16 statements could be distilled into three to five broad strategic directions.

The SOAR framework in Table 4.1 illustrates the results of this synthesis, and identifies the four high-level aspirations, or strategic directions.

Table 4.1: The SOAR Framework for the Timiskaming Health Unit

Strengths	Opportunities	Aspirations (Strategic Directions)	Results
1. External marketing/ health promotion tools, channels, materials; program specific materials. 2. Recognized as "experts" within mandated areas; local needs. 3. Leadership and collaboration around public health issues. 4. High commitment and identification of staff. 5. Generally good customer service to majority groups.	1. Refine and enhance collaborative process to address public health issues. 2. Brand management for THU (umbrella perspective). 3. Role clarification through program and service review, discussion with partners, marketing. 4. Professional Development strategy at all levels. 5. Improve delivery to populations (Aboriginal, French, low income).	1. We leverage our reliance on evidence-based research to establish ourselves as the Community Wellness Link (the "go-to agency") for all sectors of population. 2. We are building health capacity among our clients, partners and residents. 3. We are known as a workplace of choice. 4. We establish seamless and accessible communication through all five offices.	1. Set targets for health indicators, e.g. lower smoking rate by 10% in five years. 2. Invest in PD/training, identify mandated skill, individual skill, group skills. 3. Secure OCCHA accreditation. 4. Conduct a program and services review to address unmet community needs.

1. A Community Wellness Link

We leverage our reliance on evidence-based research to establish ourselves as the Community Wellness Link (the "go-to agency") for all sectors of the population.

2. Building Health Capacity

We are building health capacity among our stakeholders, clients, partners and residents. We are helping individuals and organizations develop greater self-efficacy and empowerment in supporting wise lifestyle decisions and health related public policy development.

3. A Workplace of Choice

We are known as a Workplace of Choice. This is reflected in our high levels of staff identification and commitment, excellent retention rates, and positive workplace culture.

4. Communications and Knowledge Excellence

We establish seamless and accessible communication through all offices. We have the infrastructure, applications and training to facilitate knowledge sharing, distribution and information management throughout our organization.

5.0 The Design Phase: Developing Tactics

The results of the Dream phase are summarized in Figure 5.1. The graphic presents the four strategic directions in the form of a circle to indicate the interconnectedness of the concepts. The inner circle highlights the importance of maintaining a client-focused perspective when making decisions or introducing changes in the organization. The outer circle represents the values that the THU leverages to promote and sustain its legitimacy as a health authority.

Figure 5.1: Strategic Directions for the Timiskaming Health Unit

In this section, we elaborate on each of the four strategic directions and suggest tactics the THU can implement to achieve them.

5.1. Community Wellness Link

We leverage our reliance on evidence-based research to enhance our role as a Community Wellness Link (the "go-to agency") for all sectors of the population.

The THU has established a reputation as a respected provider of health service delivery and information. Its knowledge of the local population's social and cultural characteristics is an important contributing factor to this reputation. The organization will continue to build relationships with partners throughout the region, with the goal of ensuring that Timiskaming

residents have the best possible public health care delivery system. The THU recognizes that to accomplish this, it must cultivate meaningful, collaborative working relationships with Aboriginal and Francophone clients groups, among others. As a reputable and respected health organization, the THU has an opportunity to provide leadership on coordinating cost-effective and efficient regional health promotion initiatives.

Tactics could include:

- Conduct a program and services review to address unmet needs. Clarify organizational objectives through program and service review, and discussions with partners.
- Develop a comprehensive Organizational Marketing Strategy that includes a brand equity review and corporate image development plan.
- Develop quality-management process or framework to improve delivery to underserved populations.

5.1.1 Conduct a program and services review

The THU is widely respected for its expertise and commitment to public health. There is some concern however that the THU is spreading itself too thin by "wearing too many hats," as one public consultation session participant suggested. For example, several participants noted that the THU appears to be duplicating the provision of mental health services, and suggested that the THU divert those dollars to program delivery in underserviced areas. Others felt that health services in general in the community were fragmented and confusing, and that there was no clear sense of what the various agencies were doing. THU employees also reported feeling some uncertainty as to the organization's direction and priorities.

The THU has not established a central theme for its services, and its public brand seems to be diluted. Part of this problem can be addressed by a marketing strategy (Tactic 5.1.2) that reinforces its mandate and core services.

During the consultation process, several groups independently arrived at an aspiration to have the THU recognized as the "wellness link" of the community. The THU would focus on its core services and use its expertise, knowledge and resources to build capacity in other organizations. It would become a clearinghouse of health information, simplifying the process for stakeholders and clients. Achieving this goal will require the THU to re-evaluate its priorities and develop new processes that align with a leadership and coordination role in health service delivery.

We recommend conducting a comprehensive program and services review. This process begins with the development of evaluation criteria against which each program can be measured. Criteria might include:

- Whether or not there is an established need for the program.
- Its alignment with the strategic plan.

- Whether the program is –or could be– provided by another agency.
- The impact of the program.
- The resources required to offer it.
- The public, financial and health implications of withdrawing the program.

After the evaluation process is complete, the THU may need to develop further plans to hand off some services and withdraw from others.

5.1.2 Develop an organizational marketing strategy

The THU may want to consider a marketing strategy to establish an external identity that is more in line with its long-term vision as a health services leader. The marketing strategy will also increase the public's recognition of the THU's roles in health promotion, health protection, and public policy development. This will entail refining the THU's current brand and promoting it to partners, government agencies and the public at large.

We recommend that the THU develop a comprehensive Marketing Plan, which will include:

- A comprehensive stakeholder analysis.
- A description of the THU's core products and services, including a features and benefits analysis.
- A partner analysis for all current and potential products and services.
- An advertising and promotional plan, along with a description of how it aligns with the long-term vision of the THU.
- A marketing budget.

5.1.3 Develop a quality management process for client service delivery

The community agencies with whom the THU interacts with on a regular basis agree that the THU provides high quality, reliable information and expertise. Stakeholders and community session participants expressed concern, however, that the level of client service delivery from THU varied by client group. In particular, they identified services gaps for seniors, low-income, Francophone and Aboriginal people.

We recommend that all THU program managers develop specific plans to reach all client groups. These should include well-defined processes and measurable objectives, and may address the following items:

- Staff training & recruitment to reflect the diversity of the region.
- The development of culturally appropriate marketing, programs and services.
- Partnership development to provide off-site service delivery of THU services.
- Outreach initiatives.
- Internal sharing of best practices with cultural, linguistic or other demographic groups.

5.2. Building Health Capacity

We are building health literacy and capacity among our stakeholders, clients, partners and residents. We are helping individuals and organizations develop greater self-efficacy and empowerment in supporting wise lifestyle decisions and enhancing healthy public policies.

Given the complexity of healthcare, the ongoing need for financial restraint and the challenges associated with rural and remote service provision, the THU also recognizes the need to develop complementary partnerships. The region benefits when organizations with comparative advantage focus on the areas in which they are best positioned. This reduces service duplication while ensuring that organizations focus their efforts on what they do best. The THU is thus committed to building health capacity not only in the general public, but also in organizations, especially those that may also play a role in complementary service delivery.

Tactics could include:

- Conduct local health indicator studies to establish baseline statistics (where gaps in knowledge exist).
- Set measurable targets for health indicators, e.g. lower smoking rate by 10% in 5 years.
- Conduct program/services review to address unmet needs.
- Refine and enhance collaborative process to address public health issues, including enhancing public health policies.

5.2.1 Determine local baseline statistics for health indicators

Promoting and protecting the health of the population requires a sound understanding of the unique health challenges in the population. For example, Northern Ontario residents tend to have higher rates of smoking, obesity and high blood pressure than their Southern Ontario counterparts. Understanding and quantifying the prevalence of these issues drives local program development, promotional strategies and research.

The THU operates in what is considered a rural, remote area of Ontario. Given the low population density overall, Statistics Canada (StatsCan) doesn't always provide –or collect– detailed information about the region. Moreover, the THU's jurisdiction boundaries don't align with the boundaries that Statistics Canada uses to produce its regional statistics, making extrapolation and comparisons difficult.

Collecting such information is expensive. For example, a 20-minute survey of 500 Kirkland Lake residents selected at random could cost between $5,000 and $18,000[44]. In addition, if the community of interest is very small –e.g. Larder Lake– it may be difficult to obtain statistically significant results. However, without baseline data on such issues as childhood

[44] Based on estimate rates provided by OraclePoll and Ipsos-Reid respectively.

obesity, it is difficult to develop an appropriate response in terms of scale or scope. It is also impossible to accurately measure the impact of THU interventions in such cases.

Given these issues, we recommend that the THU identify a short-list of health priorities for which it lacks meaningful data. If there is no funding available internally, the THU may have to seek funding from external sources, such as the Trillium Foundation, the Social Sciences and Humanities Research Council, and NOHFC. There may also be opportunities to work with community partners. For example, the THU could team up with area school boards on a research project to collect and monitor empirical data on childhood obesity.

5.2.2 Set measurable targets for health indicators

This tactic depends to a large extent on the ability to establish baseline statistics (Tactic 5.2.1), and thus determine what is an appropriate level of improvement. Often, just knowing what needs to be accomplished is an important step towards a successful outcome. Setting targets encourages managers to think carefully about what they expect to achieve, how they plan to do it, and the resources they need to get there.

The ideal measurable is the so-called SMART objective. SMART is a mnemonic that represents the five characteristics of meaningful objectives: Specific, Measureable, Achievable, Realistic, and Time-oriented.

- **Specific:** Write as much detail as possible while leaving enough room for reasonable flexibility.
- **Measurable:** Include quantifiable goals wherever possible, e.g. number of participants, percentage of Type II diabetes diagnoses, or rates of immunization.
- **Achievable**: The objectives must be realistic and possible to achieve within the given time frame.
- **Relevant**: The objectives must be aligned with the priorities of the strategic plan.
- **Time-oriented**: Wherever possible, provide time restrictions within which the objective must be met. This may not be possible in some situations; where this is the case, provide a rationale for not specifying a time.

Example of a SMART Objective

By the end of 2013, the THU will increase the rate of immunization for influenza among area residents by 4% over 2012. We will accomplish this by establishing greater public visibility and offering convenient access to flu shot clinics held at area shopping centres, such as Canadian Tire, Your Independent Grocer and WalMart.

Many managers and team leaders are aware of this approach, but the SMART method is often overlooked in practice.

5.2.3 Conduct program and service reviews to address unmet needs

During the consultation phase, many participants suggested programs for which they perceived a demand within the region. One example was the need for Healthy Eating Programs aimed at specific population groups. For example, in the mining and resource extraction industries, there is often a transient work population that depends on fast food or restaurant meals. Another program that would benefit the region is Prescription Safety. Many people, young and old alike, continue to take medicine from outdated prescriptions, combine medicines that are contra-indicated, and fail to store prescription medicines safely.

The THU should consider a number of factors when determining new program and service needs, such as:

- The 'fit' within the THU mandate.
- Whether other regional service partners are adequately providing this service.
- The impact on the THU budget and funder relationships.
- Whether there is expertise in house to deliver the identified service.

5.2.4 Refine partnership and collaboration framework

Both employees and stakeholders recognize that the THU is willing and able to develop and support productive working partnerships. Stakeholders value and appreciate the THU's ability to assume a leadership role, but note that at times the engagement process can be inconsistent. For example, one community partner related an incident in which the organization was asked to participate in a project after the project had been planned and finalized. The partner felt that without consultation, the partnership wasn't genuine and the relationship was compromised.

We suggest the following approaches:

- Develop a partnership framework model of best practices, including engagement strategies, communication methods, conflict resolution processes, and team building methods.
- Create a process map that identifies the structure, decision points and responsibilities of the THU and its partners relative to the specific project.
- Establish project management processes to support the collaboration and partnership framework. The Project Management Institute (www.pmi.org) is the internationally recognized leader of project management practices. Project management areas of knowledge include communications, risk management, quality management, and scope management.

5.3. A Workplace of Choice

We are known as a Workplace of Choice. This is reflected in our high levels of staff identification and commitment, excellent retention rates, and positive workplace culture.

The THU recognizes the value of building a culture of management excellence that supports, motivates, inspires and develops its employees to become the best they can be. Implementing a process to become recognized as a Workplace of Choice will improve its staff recruitment and retention efforts and build long-term commitment among employees.

Tactics could include:

- Invest in professional development and training (e.g. individual professional development plans).
- Develop an organizational human resources strategy.
- Secure Ontario Council on Community Health Accreditation (OCCHA).

5.3.1 Invest in employee development

Employee training and development is an essential aspect of good management practice, and an excellent way to build commitment, introduce efficiencies and reduce risk. A study of quality in non-profit organizations[45] found that training and development opportunities contribute towards higher worker morale, job satisfaction and organizational performance. It not only helps employees become more professional and competent at their jobs, but also increases adaptability to change. Other benefits include increased productivity, greater motivation and engagement, and reduced supervision requirements. Providing employees with challenging, self-directed work assignments and opportunities for personal and career growth are among the top reasons for organizational commitment.[46] These are all essential qualities in employers of choice.

The Ontario Public Health Organizational Standards[47] (Organizational Standards) reinforce the importance of this tactic. Section 6.14 of the Organizational Standards requires the board of health to ensure the development of a human resource strategy that, among other items, ensures clear and current job descriptions, reporting relationships, staff performance and evaluation, and succession planning. Section 6.15 of the Organizational Standards requires the board of health to ensure workforce development plans including leadership development, mentoring, and educational programs for staff. Section 6.16 of the Organizational Standards directs the board of health to support a culture of excellence that, among other results, "ensures inter-professional collaboration and learning".

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[45] McMullen, Kathryn and Grant Schellenberg (2002) "Job quality in non-profit organizations - Human resources in the non-profit sector," Canadian Policy Research Networks, at http://www.cprn.org/doc.cfm?doc=63&l=en

[46] Noe, Raymond. 2002. Employee Training and Development 2nd Edition. New York, New York: McGraw-Hill Irwin.

[47] Ministry of Health and Long-Term Care, Ministry of Health Promotion and Sport. 2011. Ontario Public Health Organizational Standards. Government of Ontario.

According to a 2007 report by the American Society of Training and Development (ASTD), organizations spend 2%-3% of their total payroll on training; they report an average annual training expenditure of $700 per person. A 2011 study[48] from Bersin & Associates supports this finding, reporting average training costs of $682 per person. They also suggest that on average, employees typically receive 13 hours of training annually.

In order to get the greatest value from limited resources, many organizations develop annual training plans to guide their decision making. Such plans must consider the needs identified in job descriptions, professional development objectives, emerging trends and strategic planning goals. For example, the THU is committed to responding more effectively to the needs of First Nations clients, so it may wish to facilitate some training on how to deliver culturally appropriate services. The THU may also wish to explore enhanced communications training options, as public consultation participants suggested that THU employees could improve their approach to counseling clients.

A training budget should consider the following items:

- Orientation of public health unit staff including reporting relationships, staff performance and evaluation processes, occupational health and safety, code of conduct and discipline and labour relations policies.
- Salaries for internal training resources.
- Fees for external trainers and curriculum developers.
- Costs for seminars and conferences, including travel.
- Specialized infrastructure, such as audiovisual equipment, broadband connections, software, etc.
- Off-the-shelf materials, including books, e-learning guides and software.
- Customized materials tailored to meet designated internal training needs.
- Facilities and overhead, such as costs for leasing training space.

When designing the organizational training strategy, ensure that the training initiatives align with specific organizational objectives and meet the Ontario Public Health Organizational Standards.

5.3.2 Develop a comprehensive human resources strategy

A human resources strategy establishes a foundation for becoming a workplace of choice. The most valuable resource in any organization is its people, particularly when the organization delivers knowledge-based services. The human resource strategic plan identifies how to attract the right number and type of people; develop their knowledge, skills and abilities; and retain them over the long term. Human resources (HR) management involves a range of activities

[48] O'Leonard, K. (2011) "Executive Summary: The corporate learning factbook 2011: Benchmarks, trends and analysis of the U.S. training market," Bersin & Associates.

that are carried out by an HR manager, line-managers and supervisors. When effectively coordinated and integrated in a planning framework, these activities can result in significant economic and cultural benefits to the organization.[49]

Typical components of a human resources strategy include:

- Workforce planning.
- Workplace culture development.
- Recruitment and selection processes.
- Orientation.
- Training and development.
- Personnel administration, discipline and recognition.
- Compensation and benefits.
- Motivation and performance appraisal.
- Labor relations.

Each component should align with and support the tactics and directions in the organization's strategic plan.

5.3.3 Secure OCCHA Accreditation

The Ontario Council on Community Health Accreditation (OCCHA) promotes accountability and excellence in public health programs and services. Accreditation is based on the notion that delivering public health requires proven administrative and operational processes. Through the accreditation process, OCCHA provides an independent, voluntary, peer evaluation of the administrative and operational aspects of local public health agencies.[50]

Accreditation provides a range of benefits to health units, many of which will facilitate and complement tactics under the other three strategic directions. According to OCCHA, accrediation :

- Demonstrates the Health Unit's accountability to funding agencies and to the public.
- Reflects the organization's commitment to excellence and quality.
- Enhances perceptions of credibility and legitimacy among clients and partners.
- Facilitates Continuous Quality Improvement within the organization.
- Builds and improves staff morale.
- Celebrates and recognizes the Health Unit's achievements.
- Establishes processes that facilitate information sharing.
- Helps agencies respond to changes in the public health arena.

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[49] Armstrong, Michael (2006). A Handbook of Human Resource Management Practice. London: Kogan Page.
[50] Ontario Council on Community Health Accreditation. Available at http://www.occha.org.

Currently, the Northwestern, Algoma and Sudbury Health Units are accredited. The process involves establishing and meeting standards in six areas, as illustrated in Table 5.1.

Table 5.1: The Six Sections of OCCH Accreditation

	Sections	Subsections	Component of Strategic Plan that the section complements and supports
1	Leadership	• Strategic Directions • Governance • Agency Management	• Building management capacity, as per Tactic 5.3.1. • Reviewing and refining program offerings, as per Tactic 5.2.3.
2	Organizational Capacity	• Organizational Structure • Resource Management • Records Management	• Information and knowledge management, as per Tactic 5.4.3.
3	Workforce	• Staffing • Training/Education/Skills • Performance Evaluation	• Developing employees, as per Tactic 5.1.1. • Information and knowledge management, as per Tactic 5.4.3.
4	Partnerships and Collaboration	• Collaboration	• Refining processes for building and managing partnerships, as per Tactic 5.2.4.
5	Programs	• Research and Knowledge Exchange • Planning/Implementation • Health Promotion • Health Protection and Disease Prevention • Monitoring/Evaluation • Public Health Emergency Preparedness and Risk Management	• Reviewing and refining program offerings, as per Tactic 5.2.3.
6	Communication	• Internal Communication • External Communication	• Communication to all offices as per Tactic 5.4.2.

5.4. Communications and Knowledge Excellence

We establish seamless and accessible communication through all offices. We have the infrastructure, applications and training to facilitate knowledge sharing, distribution and information management throughout our organization.

Communication forms the foundation of an effective, productive and positive organizational culture. The THU will develop and implement a framework that supports more transparent, frequent and meaningful communication among offices, departments, programs and employees. The organization will evaluate its current approach to knowledge management and

sharing in order to ensure that this essential resource is leveraged to the greater benefit of employees, partners and clients.

Tactics could include:

- Invest in professional development and training for managers and administrators (e.g. in organizational communications, knowledge management applications, etc.).
- Develop a comprehensive Organizational Communications Strategy that addresses internal communications needs.
- Review best practices in knowledge management from other health units to develop appropriate protocols for THU.

5.4.1 Invest in management development

Good managers coach, mentor, lead, motivate and inspire employees, and are responsible for establishing and maintaining a positive, productive and innovative workplace culture[51]. Management skills not only improve leaders' ability to manage organizations from a strategic perspective, but also improve relationships and general well-being[52] among employees. Skilled managers prevent and mediate conflicts, monitor and support employee performance, and communicate professionally and positively with personnel and clients alike. Ultimately, good managers contribute to a more favorable workplace culture by role modeling and providing positive reinforcement for appropriate behaviours and activities.

Most of us benefit from learning both the formal and soft skills needed to develop the capacity that makes us effective in a management role. Management skills are typically divided into two categories: personal skills and interpersonal skills. One commonly used framework for teaching management skills in universities advocates nine key topic areas: three intrapersonal skills (self-awareness, creative problem solving, stress management) and six interpersonal skills that are either implicitly or explicitly linked to good communication (conflict management, motivating, influencing, empowering and delegating, supportive communication and teamwork)[53].

There are several options to consider for management training, including:

1. In-house self-guided programs that use proprietary or local-developed materials and resources. Typically, these consist of different levels of programming that cover checklists of skills the organization deems important. Such programs require

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[51] Porter, L. W., & McKibbin, L. E. (1988). *Management education and development: Drift or thrust into the 21st century?* New York: McGraw-Hill.
[52] Whetten, D. A., & Cameron, K. S. (2001). *Developing management skills* (5th ed.). Upper Saddle River, NJ: Prentice Hall.
[53] Clark, Sue Campbell, Ronda Callister and Ray Wallace (2003) "Undergraduate Management Skills Courses And Students' Emotional Intelligence," *Journal of Management Education* February 27(1), 3-23.

individuals to accomplish a series of readings, courses and on-the-job evaluations by senior personnel to ensure that they have the skills appropriate to their particular position. The initial cost of developing a practical, meaningful in-house training program is usually offset by ongoing savings after the program is implemented.

2. External professional development courses on specific areas of expertise. Examples include Management Communications Skills, Motivating and Evaluating Employees, Leadership Skills, and Knowledge Management. Such courses can be delivered through self-paced or classroom mechanisms, either on or off-site. Ongoing expenses are likely to be higher than for a strictly in-house program of training, especially if there is travel involved. However, the choice of subject material is considerably broader, and an external perspective can be a valuable source of inspiration and renewal for employees.
3. Certificate or degree programs through colleges and universities. This tends to be the most expensive option, and is thus more common in government and private sector organizations. However, such programs may also be available within non-profit organizations as a means of motivating and keeping skilled people in management positions over the long term.

Organizational training strategies often include combinations of these options to meet specific organizational needs.

5.4.2 Develop an organizational communications strategy

An organizational communication strategy is usually defined as a plan that outlines how an organization will communicate with its internal stakeholders, including Board members, managers and front-line staff. It is distinct from the marketing strategy, which focuses on how the organization promotes itself to external stakeholders, such as clients, the government, the media and the community.

A good strategy covers mechanisms for both formal and informal communications, and considers both bottom-up and top-down channels. Effective communications throughout an organization can:

- Increase employee satisfaction and engagement.
- Ensure that employees understand the expectations of the organization.
- Develop trust, commitment and loyalty.
- Help employees understand how they fit into the organization, and how their work contributes towards organizational goals.
- Encourage innovation, institutionalizes best practices and ultimately creates greater efficiencies.

A strategy should focus on linking communications efforts with operational priorities. It must facilitate the communication of consistent and accurate messages, and reinforce organizational goals, objectives and policies. It should allow for a dialogue. In other words,

organizational communication should be a two-way street. By regularly engaging and listening to employees, senior management can learn about and respond to concerns before they become full-blown problems.

A comprehensive strategy should address the following elements:

- Stakeholder analysis: should all communications be issued to all staff members, or should some be tailored to the needs of front-line, managers, union representatives? This includes an analysis of communications channels and their specific needs: e.g. Manager to supervisor communications methods may be very different from those between supervisors and front-line staff; these may vary in content, delivery method and frequency.
- Communication roles and responsibilities of key leaders, including managers, supervisors, union representatives and committee heads.
- Communications vehicles, e.g. newsletters, intranet, bulletin boards, memos, staff meetings and staff retreats.
- Opportunities for listening to and getting feedback from employees, e.g. employee surveys, staff meetings, suggestion boxes and project committees. Ideally, this would be complemented by a communications policy that commits the organization to responding to employee feedback.
- Communications training initiatives to support managers and supervisors.
- A set of criteria that determines if and when managers should communicate about an emerging issue, and how it should be done.
- A budget that effectively supports the communication initiatives.

5.4.3 Develop knowledge management protocols based on best practices

The Timiskaming Health Unit is well known for its reliance on research and empirical evidence in creating and implementing sound public health policy. The sheer volume of data around health research, demographics, policies and protocols creates significant knowledge management challenges. For example, how can a Health Unit employee transfer information from a conference to other employees? How are the lessons learned from health program implementation captured and used to improve subsequent initiatives? How can best practices in one department be codified and applied to other programs?

Knowledge management is the systematic capture, use, and application of information, experience, and expertise to achieve organizational goals. It involves leveraging knowledge to innovate and improve upon its core competencies. Research suggests that knowledge management systems can facilitate both efficiency and quality of health services[54, 55].

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[54] Carasso, S. T. Arbiv, I. Yariv, E. On, I.Ashkenazi and H. Levi (2005) Knowledge management in health organizations. Harefua, 144(7), 474-479.

[55] Wickramasinghe N. Bali, R and Geisler E.(2007).The major barriers and facilitators for the adoption and implementation of knowledge management in healthcare operations, International

There are two types of knowledge: explicit and tacit. Explicit knowledge is any form of information, expertise, or experience that can be articulated, expressed, recorded and transmitted. The most common forms of explicit knowledge include documents, diagrams, processes, databases and videos. Tacit knowledge is experiential, and is reflected in sense of shared beliefs, values, norms and mental models that we often take for granted. It tends to be knowledge that is difficult to communicate to others via words and symbols, and is passed on through experience. Examples include discovering what motivates a client to change unhealthy behaviours, and resolving a conflict between co-workers. These are things that employees can learn how to do, but that are not easily reduced to rules or step-by-step processes.

Both types of information can and should be captured so that employees need not reinvent the wheel each time they face a challenging situation. Tacit knowledge can be collected by regularly identifying and interviewing the subject area experts in the organization, or by holding focus groups. The interviews and conversations are then parsed to identify which content is helpful, what processes worked best for a given issue and what pitfalls to avoid. Another method of capturing tacit information is to hold debriefings at major project milestones, and to record best practices, lessons learned, and recommended changes to processes going forward.

We suggest the THU explore options for more effective collection, storage and dissemination of information. Its tasks should include:

- Develop an inventory of explicit knowledge and resources.
- Identifying subject area experts or those organizational members with significant tacit knowledge.
- Conduct an audit that identifies knowledge bottlenecks and unique sources of information.
- Consult with other Health Units and agencies to determine how they manage data, information and knowledge.
- Research best practices in knowledge management for health care providers.
- Identify applications, infrastructure and training necessary to collect and store information.
- Develop a system for inputting, managing and accessing explicit knowledge.
- Prepare a plan to capture and store tacit knowledge.

6.0 The Delivery Phase: Implementation

Implementation is always the most challenging aspect of a strategic planning process. According to some researchers[56], fewer than half of the organizations that develop a strategic plan actually implement it. One Ernst and Young study (2008) found that the number failing to execute their strategies was as high as 66%.

A McKinsey survey (2006)[57] identified a number of reasons for this phenomenon, including:

- Lack of involvement from partners and stakeholders.
- Insufficient alignment of organizational goals with the strategic plan.
- Insufficient involvement from senior management and project leaders.
- Insufficient involvement from boards of directors.
- No method to monitor progress against the strategic plan.
- Failure to adequately communicate the objectives of the plan throughout the organization.

The THU mitigated some of these risks at the outset by establishing a Strategic Plan Working Group to ensure that the directions and tactics align with the THU's mandate and operational priorities. Its senior management was involved throughout the process, providing guidance and input on everything from the consultation framework and survey tools to the various document drafts. The THU meaningfully involved as many employees as possible in the planning process via formal employee summits. They oversaw the development of public consultations, focus groups and interviews to engage and involve its stakeholder groups and the community at large.

Figure 6.1 on the following page illustrates each of the Strategic Plan tactics along a timeline from 2012-2017. The timeline is not meant to be written in stone; given changes in funding, resources and the external environment, the order and timing of projects may change over the course of the plan. The timeline can be useful tool for monitoring the plan, allocating staffing resources, demonstrating progress and celebrating major milestones.

We suggest that after the Strategic Plan is finalized, senior management meet to assign responsibilities for the various tasks to individual project leads. You may also wish to present strategic plan updates at each Board meeting to make sure that it remains relevant, and to motivate the project leads to make demonstrable progress on their tasks.

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[56] Johnson, L.K. (2004), "Execute your strategy without killing it," Harvard Management Update, Boston: Harvard Business School Publishing.
[57] Improving Strategic Planning: A McKinsey Survey (2006) McKinsey Quarterly, July/August.

Table 6.1: Suggested Implementation Timeline

	Strategic Plan Tactic	2012		2013				2014				2015				2016				2017	
		Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
5.4.2	Develop a comprehensive Communications Strategy	■	■	■																	
5.3.1	Develop professional development plan			■	■	■	■	■													
5.2.3	Conduct a review to address unmet needs		■	■	■	■	■														
5.4.1	Management development					■	■	■	■	■	■	■									
5.1.1	Clarify objectives with program and service review				■																
5.3.2	Develop human resources strategy					■	■	■	■	■	■	■	■								
5.2.4	Refine and enhance collaborative process								■	■											
Review and refine Strategic Plan			■				■				■				■				■		
5.3.3	Secure OCCH Accreditation							■	■	■	■	■	■	■	■	■					
5.4.3	Implement best practices in knowledge management												■	■	■	■	■				
5.1.3	Develop quality-management process														■	■	■	■			
5.2.1	Establish baseline statistics (to address knowledge gaps)																■	■	■		
5.2.2	Set measurable targets for health indicators																■	■			
5.1.2	Develop Organizational Marketing Strategy																■	■	■	■	■

6.1 Best Practices for Implementing Strategic Plans

There are some established tactics for maintaining the momentum of strategic plan projects and keeping them relevant.[58,59]

1. Establish a diverse advisory committee to monitor and guide the implementation of the plan. The Committee members must make a firm commitment to collaborate, and should establish a Terms of Reference to establish the ground rules. Throughout the relationship of the collaborative, the Chair should be aware of the trust level of the group. If something happens that endangers trust, the Chair must take action to repair the trust and keep it growing.[60]
2. Encourage broad organizational ownership and accountability for the implementation of the plan, but identify one key project lead to follow through on each goal.
3. Embed the strategic plan into the daily operations of employees.
4. Develop written criteria to monitor and evaluate the performance of strategic planning[61]. The Steering Committee should not only monitor the progress and oversee the group's efforts, but should also continuously evaluate the work it has done. By doing so, the collaborative can identify mistakes and correct them to ensure that it reaches its goals. Evaluation will also help build the collaborative's credibility so that it can increase its potential to accomplish more in the future.[62]
5. The Steering Committee may wish to hold monthly strategy meetings to discuss the status of the plan, troubleshoot problems and cross off what has been completed.
6. Lead by example. Managers, leaders and administrators must demonstrate commitment and consistency in aligning decisions with the strategic plan. When making budget decisions, all partners committed to implementing the strategy should refer to the plan.
7. Appoint a single, recognized plan leader or coordinator. This individual should track, monitor, and facilitate objectives and reports on progress. The leader should be respected by other project leads involved in implementing the plan. Research also suggests that plans are more likely to be implemented when the management structure is considered "stable" (as opposed to experiencing constant turnover).[63]

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[58] http://mystrategicplan.com/resources/ten-things-to-keep-your-strategic-plan-from-hitting-the-shelf/

[59] http://www.nekls.org/it%E2%80%99s-alive-keeping-your-strategic-plan-vital/

[60] For more information on building multi-sector collaboratives please see the University of Kansas' Community Tool Box website: http://ctb.ku.edu/en/tablecontents/sub_section_main_1385.aspx

[61] Dusenbury, P. (2000). Strategic Planning and Performance Measurement. Washington, DC: Governing for Results and Accountability Project, The Urban Institute.

[62] Community Toolbox: Developing Multi-sector Collaborations: see website http://ctb.ku.edu/en/tablecontents/sub_section_main_1385.aspx

[63] Wheeland, C. (2003). Implementing a Community-Wide Strategic Plan: Rock Hill's Empowering the Vision 10 Years Later. *American Review of Public Administrations*, 33: 1, 46-69.

8. Communicate the plan using different methods. Traditional methods of communicating the plan include holding an official launch, printing posters with a summary of the plan, and distributing the full plan to each employee.
9. Keeping the strategic plan alive requires constant monitoring, evaluation and communication. Annual updates and the use of a scorecard could be used to visually communicate the action items and their status. Progress should be regularly updated on the organization's website, newsletter and at meetings.
10. Celebrate successes early and often. Don't wait until the end of the year to recognize achievement. Celebrate successes, big and small, along the way to keep everyone engaged and excited.

Appendix A: Organizational Partners Consulted

Organizations Participating in Stakeholder Interviews

Agency	Phone	Address	Rationale for Interview
Ontario Provincial Police	705-647-8400	28 Wellington Street S New Liskeard, ON P0J 1P0	• Partners on committee
Centre de Santé Communautaire du Temiskaming	705-647-5775	P.O. Box 38 New Liskeard, ON P0J 1P0	• Partner in programs • Opportunities to share resources
Timiskaming-Cochrane Ontario Early Years Centre	705-672-2100	76 Rourke Avenue/Box 2070 Haileybury, ON P0J 1K0	• Priority populations partners
Temiskaming Hospital	705-647-1088-2220	421 Shepherdson Road New Liskeard, ON P0J 1P0	• Infection Control • Newborn post screening • Partners/Data Sharing
Englehart and District Hospital	705-544-2321	P.O. Box 69 Englehart, ON P0J 1H0	• Infection Control • Newborn post screening partners
Canadian Mental Health Association (CMHA)	705-647-4444	P.O. Box 249 New Liskeard, ON P0J 1P0	• Partner
Kirkland and District Hospital	705-567-5251	145 Government Road Kirkland Lake, ON P2N 3P4	• Infection Control • Newborn post screening • Partners/Data Sharing
Community Care Access Center	705-567-2222	P.O. Box 520 Kirkland Lake, ON P2N 3J5	• Partner • Priority populations
Timiskaming Social Services Administration Board	705-647-7447	PO. Box 310 29 Duncan Ave North Kirkland Lake, ON P2N 3H7	• Provide funding for a number of our programs • Partners on committees
Timiskaming Brighter Futures	705-672-3333	Kirkland Lake Office	• Priority populations • How we can better serve this population?
Timiskaming Child & Family Services	705-647-5437	Kirkland Lake Office	• Partner, provide services with them (mental health)
DSBONE	705-360-1151	153 Third Avenue Schumacher, ON P0N 1G0	• Improve partnership • Mandated to work with them, they are not with us • Infection Control

Agency	Phone	Address	Rationale for Interview
Northeastern Catholic District School Board	705-544-2397	101 Spruce Street N. Timmins, ON P4N 6M9	• Improve our partnership • Mandated to work with them, they are not with us • How to connect? • Infection Control
Conseil scolaire catholique de district des Grandes Rivières	705-647-7304	896 promenade Riverside, Timmins, ON P4N 3W2	• Improve our partnership • Mandated to work with them, they are not with us • How to connect? • Infection Control

Family Health Team and Organizational Surveys Administered Online

Agency	Telephone	Address	Rationale for Interview
Tri Town Extendicare	705-672-2151	P.O. Box 999 Haileybury, ON P0J 1K0	• Infection Control
Northdale Manor	705-647-6992	P.O. Box 370 New Liskeard, ON P0J 1P0	• Infection Control
Temiskaming Lodge	705-672-2123	Haileybury	• Infection Control
Family Health Team Haileybury	705-672-2915	494 Ferguson Avenue Haileybury, ON P0J 1K0	• Data Sharing
Great Northern Family Health Team	705-647-6100	285 Whitewood Ave. W. New Liskeard, ON	• Data Sharing
KL Extendicare	705-567-3268	155 Government Road East Kirkland Lake, ON P2N 1A9	• Infection Control
Family Health Team Kirkland	705-567-2224	P.O. Box 10 Kirkland Lake P2N 3M6	• Data Sharing

Appendix B: Ontario's Action Plan for Health Care - Highlights

Ministry of Health, February 2012. Ontario's Action Plan For Health Care: Better patient care through better value from our health care dollars

Excerpt

Our goal is to make Ontario the healthiest place in North America to grow up and grow old. (p.3)

Indeed, if we didn't change anything, kept the age-specific costs what they are today and applied them to the 2030 population, our health costs would increase by $24 billion – 50 per cent more than today from changing demographics alone.

Even if the province wasn't facing serious economic pressures, the health care system would still need to transform to address the coming demographic shift.

Today, health care consumes 42 cents of every dollar spent on provincial programs. Without a change of course, health spending would eat up 70 per cent of the provincial budget within 12 years, crowding out our ability to pay for many other important priorities.

These demographic changes are happening concurrently with the province's need to reduce the historical growth of health spending as we continue to cope with the global economic downturn, and eliminate the provincial deficit.

Limited resources will require us to choose carefully between health priorities so that we can best serve patients as we transform our system to improve quality of care. Health care dollars must be shared between hospitals, doctors, long-term care, palliative care, drugs, home care and other services. Money spent in one area simply means that there is less funding available to pay for the needs in another area. We're going to have to make tough trade-offs and shift spending to where we get the best value for the dollar. For example, a one per cent increase in compensation to physicians is equivalent to the funds needed to pay for home care for 30,000 seniors. A one per cent increase in funding for hospitals is equivalent to the funds needed to pay for over five million hours of home care (p.5).

Our Action Plan

Our plan is obsessively patient-centred. As a result, our priorities are based on what you, the patient, should be able to expect from your health care system.

Ontarians should have:

1. Support to become healthier

2. Faster access and a stronger link to family health care
3. The right care, at the right time, in the right place

We have a plan to transform Ontario's health care system to meet these goals for patients and ensure our system is sustainable for our children and grandchildren. We will achieve our objectives in the same way we have achieved our progress to date — by working together with all our partners across Ontario's health care system. Change will not always be easy, and will not happen overnight. However, by working together, this plan will become reality.

Keeping Ontario Healthy – Prevention (p.7)

Helping people stay healthy must be our primary goal and it requires partnership. As a government, we're increasingly putting our efforts into promoting healthy habits and behaviours, supporting lifestyle changes and better management of chronic conditions. But to succeed, we need everyone to play an active role in their health care by participating in healthy living and wellness, while also taking advantage of recommended screening and vaccination programs. Here are some key next steps we will take, in partnership with Ontarians, to promote better health.

Childhood Obesity Strategy (p7)

Obesity in childhood contributes to the rise in life-long chronic diseases, such as diabetes, cancer and heart disease. Some experts suggest that this generation of children could live shorter lives than their parents, so we must take action today. We will aggressively take on the challenge to reduce childhood obesity by 20 per cent over five years. Success on this front will require partnership, so we will bring together a panel of advocates, health care leaders, non-profit organizations, and industry to develop the strategy to meet our target. This panel will report back to us by Fall 2012

While the demographic shift compels us to reform health care, today's fiscal reality requires that we act now to make Ontario's health care system sustainable. But sweeping cuts to health care aren't the answer — this has been tried before, and would not serve Ontarians well. What is needed is an action plan to create a system that delivers care in a better way — a smarter way. One that improves quality for patients as it delivers increased value for taxpayers.

Mental Health (p11)

Nowhere is early intervention more important than in mental health.
Seventy per cent of mental health problems first appear in childhood and adolescence. That's why we will implement our mental health strategy starting with children and youth, including getting mental health nurses into our schools, supporting people with eating disorders, and smoothing the transitions of people between mental health care providers.

Local Health Integration (p.12)

The creation of our Local Health Integration Networks (LHINs) has improved the integration of our health care system at the local level. Care is more cohesive, and providers are working together more. In short, the system is beginning to operate more like a system. This is the beginning of an evolution towards better integration, and system accountability for improved patient outcomes.

However, if we are to meet the needs of a growing population with multiple, complex and chronic conditions, our health care system must be even better coordinated, with seamless levels of care. In addition to integrating family health care into LHINs, we will introduce further reforms to promote more seamless local integration, with fewer layers of administration, to ensure we have a system truly structured around the complex needs of an aging population.

This integration will be particularly crucial in our effort to better serve the one per cent of the population that accounts for 34 per cent and the ten per cent of the population that accounts for nearly 80 per cent of our health care spending. With greater patient-centred integration across all facets of the patient journey, these patients will have a better coordinated plan of care, while gaining greater value from the system.

Appendix C: Selected Health-related Items from the Ontario Budget 2012

This summary is from the Ontario Association of Local Public Health Agencies[64]

Prepared by Gord Fleming
Association of Local Public Health Agencies
March 27, 2012

The 2012 Ontario Budget is strongly focused on deficit reduction and much shorter on policy interventions than usual. As expected, the major theme is eliminating the deficit by 2017-18 with restraint in all sectors while preserving the marquee items of Education and Health Care, where growth will continue albeit at a reduced rate. Keeping health care and education strong is a key talking point, and continuing the implementation of full-day kindergarten warrants its own.

In general, restraint will be achieved through a combination of compensation levers (i.e. enhancing the public sector wage freezes that were introduced with mixed results two years ago), reduction of the Ontario Public Service (through attrition and "other measures") and other efficiencies. The theme that you will likely hear repeated is that for every dollar in revenue solutions, there will be four dollars in expenditure solutions to achieve a balanced budget.

Public health is not mentioned at all, but there are some noteworthy passages that will be of interest to alPHa's members.

Education

- As mentioned above, province-wide implementation of full-day kindergarten is expected by 2014 (9)

Health

- Health care is to be "transformed", to ensure a rate of growth of not more than 2.1% annually over three years. The details of this are laid out in the previously-released Ontario Action Plan for Health Care (3).
- The OAPHC key strategy of preventing illness and helping Ontarians stay healthy and active by focusing on health promotion, including reducing childhood obesity and smoking rates is reiterated (23), as is the pledge to set up an expert panel to address the former (25).
- Family health care is the only service specifically identified as being integrated with the LHINs (26).
- The Government will "shift spending to where it has the greatest value and health care benefit" (175). It does not mention public health here, instead emphasizing home and

[64] http://www.alphaweb.org/files/ONTARIO%20BUDGET%202012%20HIGHLIGHTS.pdf

community care, but it is a turn of phrase that public health may wish to repeat in its advocacy efforts.

Environment

- Shutting down coal-fired power stations and becoming a North-American leader in the provision of clean and safe drinking water are cited as achievements related to supporting a healthy Ontario (22).
- The pledge to phase out coal fired electricity completely by 2014 is repeated (46)

Social assistance

- Recommitment to following the advice of the Commission for the Review of Social Assistance in Ontario to improve outcomes and sustainability (43)
- There will be no increases to rates at this time (44).
- The incremental increases to the Ontario Child Benefit will be slowed somewhat, rising from 1,100 to 1,210 in July 2013 and then to 1,310 the next year (45)

Other

- Under maximizing the value of public assets, the Liquor Control Board of Ontario will be directed to implement new measures to deliver an additional 100M in revenue to the Province. They will "enhance profitability in a socially responsible manner" (97). Public health may want to keep an eye out to make sure that this is so.
- Ontario Lottery and Gaming will also be enhancing revenues through increasing sales at major retail outlets (98)

Tobacco Enforcement

- This has its own section under the "Tax and Pension Systems" chapter. Pledges are made to increase fines on those convicted of selling tobacco to youth and to impose stronger sanctions for repeat offenders of Ontario's tobacco-related laws (selling prohibitions on both tobacco and lottery tickets for example). It further pledges to further educate the public about health and social problems associated with tobacco and to undertake research to measure the impact of tobacco control strategies. A promise to "double enforcement efforts" is also made, referring specifically to contraband (258).

The Ontario Public Health Association Budget Response:
OPHA concerned about missed opportunities in 2012 Ontario Budget

TORONTO, March 28, 2012–The Ontario Public Health Association (OPHA) is pleased to see that the 2012 Ontario Budget does not reduce or freeze health care spending for the next three years. However, OPHA is disappointed that there are no substantive investments in disease and injury prevention, health promotion or in public health. Such investments would have reflected the Ministry of Health and Long-Term Care's commitment to disease prevention and health promotion, which was identified as part of Ontario's Action Plan for Health in

January, and that OPHA supported. There are also few details on the Budget's financial impact on the public health sector, although we anticipate there will be a modest funding increase.

The lack of funding clarity and substantive investments in disease and injury prevention represent a missed opportunity for slowing the future health care spending growth rate – a stated goal of the provincial government.

Despite our reservations regarding overall public health investments, OPHA welcomes the increased attention the provincial government is paying to keeping patients and clients at home longer. This presents an opportunity for public and community health professionals to play a significant role in optimizing prevention and health promotion efforts. This includes an active role in healthy ageing such as encouraging healthier lifestyles and creating safer environments among this population.

The OPHA is also concerned about the Budget's impact on issues related to the social determinants of health. The government's decision to freeze social assistance rates and to delay the increase in the Ontario Child Benefit are examples of how the health equity gap may widen and put increased financial strain on our health care system downstream.

The OPHA looks forward to working with the government to develop funding and policy opportunities that will instill a greater focus on health prevention to ensure a healthier population and reduced government costs.

Appendix D: Selected Recommendations from the Drummond Report

Excerpt from the Drummond Report Executive Summary (p.25)

> The province should do more in the area of disease prevention and health promotion. Much public health work is done outside the primary health care sector. Funding for public health is strongly linked to municipal budgets. Municipalities now put up 25 cents of every public health dollar; many are now considering spending cuts that put public health units at risk of losing provincial support. The province should consider fully uploading public health to the provincial level. Better co-ordination of the public health system is needed to include hospitals, community care providers and primary care physicians. Ontario should copy British Columbia's Act Now initiative, which has been cited as a best-practice example for health promotion and chronic disease prevention. Doctors could do their part by addressing diet and exercise before reaching for the prescription pad. Patients should heed their doctor's advice and make lifestyle changes when requested. The province should do more to reverse the trend in childhood obesity and explore regulatory options for the food industry.

Specific Drummond Report recommendations that relate to Health Units:

Health Promotion and Prevention (p. 193)

Recommendation 5-78: Integrate the public health system into the other parts of the health system (i.e., Local Health Integration Networks).

- Much public health work is done outside the primary health care sector, for example, in matters of settlement and housing. The potential impacts of budget integration should be taken into consideration as the funding sources for public health are strongly linked to municipal budgets.

Recommendation 5-79: Review the current funding model that requires a 25 per cent match from municipalities for public health spending.

- Many municipalities are now reducing their funding, which puts public health units at risk of losing provincial support as a result of municipal cuts.

Recommendation 5-80: Consider fully uploading public health to the provincial level to ensure better integration with the health care system and avoid funding pressures.

Recommendation 5-81: Improve co-ordination across the public health system, not only among public health units, but also among hospitals, community care providers and primary care physicians.

- With the advent of LHINs, hospitals refocused on acute care and core services, but as an unintended result, they began pulling back on public health functions such as diabetes counselling.

Recommendation 5-82: Replicate British Columbia's Act Now initiative, which has been

identified by the World Health Organization (WHO) as a best practice for health promotion and chronic disease prevention, in Ontario.

- There appears to be some correlation between health outcomes and the amount provinces spend on public health. A 2009 study by Douglas Manuel (D. Manuel et al., "What Does It Take to Make a Healthy Province?" Institute for Clinical Evaluative Sciences, 2009, p. vi. and others) revealed that British Columbia, which spends almost three times as much per capita on public health as Ontario, is the leading province in terms of overall population health and health behaviours (including quitting smoking, engaging in regular physical activity, choosing a healthy diet and maintaining a healthy body weight). This apparent correlation between public health spending and health outcomes needs to be further explored through research to determine the benefit-cost ratios.

Recommendation 5-83: Have doctors address diet and exercise issues before reaching for the prescription pad when dealing with health issues such as cardiovascular disease and late-onset Type 2 diabetes.

- Patients need to heed their doctor's advice and make lifestyle changes when requested.
- For example, the cholesterol-lowering medication Lipitor has been the biggest selling drug for over 10 years, in some years exceeding $1 billion in sales. As Lipitor is the most-often prescribed drug in Canada for those over age 65, this means that the ODB program is covering a substantial cost that could be potentially alleviated, at least in part, by lifestyle changes in Ontarians.

Recommendation 5-84: Do more to promote population health and healthy lifestyles and to reverse the trend of childhood obesity, especially through schools.

- In addition, the government should explore regulatory options for the food industry. This would require the integration of health promotion activities with municipalities and school boards, among others. It will be important to take a whole of government approach to population health and include population health in planning considerations.

Recommendation 5-85: Work with the federal government on nutrition information and, where appropriate, regulation.

- If we apply the WHO population attributable risk estimates to Canadian mortality statistics, nutrition-related chronic diseases now cause some 48,000 deaths annually in Canada and perhaps some 16,000 deaths in Ontario. If the federal government does not act in a timely fashion, Ontario should act alone in areas such as restricting the amount of trans fat and sodium permissible in restaurant and manufactured foods, and establishing a provincial chronic disease prevention strategy, including nutrition, tobacco, alcohol and physical activity measures.