Health and Social Services Strategic Plan

2014-2019

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Healthy communities – wellness for all

Yukon
Government

Message from the Minister

It is my pleasure to present the 2014-19 five year strategic plan for Health & Social Services. This plan describes our objectives and outlines the key strategies the department will be implementing over the next five years, in pursuit of its identified goals and ultimately the vision of healthy communities and wellness for all.

Over the past few years, much work has been done towards fulfilling many of the commitments made by our government in 2011. Support of non-governmental organizations in addressing needs of various populations; increased emergency shelter options for vulnerable youth and adults; new legislation regulating Nurse Practitioners; establishment and strengthening of partnerships aimed at supporting persons with FASD – these are just a few examples of progress we've made towards the commitments relevant to this department and are all part of a strategic focus on our vision.

The goals and strategies outlined in this plan will further the progress being made towards improving access, quality, and sustainability. We can expect to see continued work on mental health and substance abuse; improved integration of delivered services; ongoing work on recruitment and retention; integration of a wider range of health professionals and programs, and more.

Accompanying this work is an increased focus on accountability and an ongoing need to manage cost escalation. Ensuring that Yukon residents have appropriate access to a continuum of social supports and health services requires a significant investment, resulting in the budget for Health and Social Services being the largest of any Yukon government department. This price tag and the importance of the work that we and our partners carry out necessitate good governance; accountability; and effective planning processes, to maximize resources while ensuring the best possible outcomes for our population. Health and Social Services staff are committed to using best evidence to guide practice and evaluate outcomes, ensuring that the services we offer are meeting the needs of our population in the best and most cost-effective way possible.

Meaningful improvements in health and well-being across the population will require the Department of Health and Social Services to move to Client/Patient-centred delivery; to work with our system partners in new ways; and to lead in cross-ministry collaboration to address both immediate needs, and as much as possible, those factors that impact our well-being from infancy to our older years. We, collectively, need to explore a new model of service and support delivery that works to build a new, unified identity of coordinated service and Client-oriented care.

As outlined in this plan, over the next five years we envision making progress towards our vision of healthy communities and wellness for all by focusing on three departmental goals. The gains realized in this five year period will mark the first stage of a long journey – a journey towards system transformation that began with the Needs Assessment for Watson Lake and Dawson City; followed by the information and evidence gathering phase of the Clinical Services Plan; and that will continue to be shaped by evidence, our values and our vision in the years to come.

1. Optimal physical and mental wellbeing
   We will place focus on areas of health promotion and risk reduction; child development; mental wellness; chronic condition management, and environmental health risks.

2. Safety and well-being for vulnerable and 'hard-to-serve' populations and those with complex conditions
   We will expand service options for persons with addictions and mental health issues; collaborate with system partners in addressing service gaps for 'hard-to-serve' persons; implement evidence-based interventions for vulnerable populations and improve identification and understanding of those with complex needs through integrated case-management. We will support vulnerable and hard-to-serve persons in achieving and maintaining optimal independence and community inclusion.

3. Access to integrated, quality services
   Both within Whitehorse and the smaller communities, we will change how and where residents are accessing service in order to improve their access and experience. We will do this by ensuring a variety of health and allied professionals work together to provide quality care in our smaller communities. We will use innovative ways to deliver

services, such as through expanded use of Telehealth. We will support residents in accessing care locally, outside of a hospital setting (where appropriate), reducing the burden on our hospital system with the result being improved care experiences for Patients and Clients.

Beyond our focus areas, we will improve and expand upon performance measurement across the department, so we can ensure that our work is having the intended impact, and so we can examine factors and make appropriate adjustments when outcomes are not what we expect.

Progress on these goals, most importantly, will lead to improved outcomes in the population. Improvements in those factors that impact health, while vital at all ages, will have particular impact for our youngest residents, in leading to reduced risk of chronic conditions throughout life.

I am confident that the 5-year plan laid out in the following pages will support progress towards our aim of healthy, vibrant communities and populations; maximized use of limited resources; innovative approaches to increase access and quality; Patient/Client-centred service delivery; appropriate resource use; and Yukon services, designed and structured based on needs and aligned with best practices.

Through reduced risks of injury and disease; improvements in wellness for those with health challenges; and effective and appropriate changes to our services, we will see a population better able to live fully and a system better able to handle new issues and opportunities that may arise. Achieving this will require working together with partner organizations and empowered, informed residents, and we hope you will join us in accepting this challenge.

Sincerely,

Minister
Health and Social Services

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Vision, Mission, Values and Strategic Goals

Where We're Going – Our Vision:

Healthy communities – wellness for all

What We Do – Our Mission:

To promote, protect, and enhance the well-being of Yukon people through a continuum of quality, accessible, and appropriate health and social services.

How We Will Get There – Our Strategic Goals

Department Goals

1. Optimal physical and mental wellbeing
2. Safety and wellbeing for vulnerable/'hard-to-serve' populations and those with complex conditions
3. Access to integrated, quality services

Corporate Goals

4. Talented people are recruited, developed, and engaged to provide high quality service to the public
5. Open, accountable, and fiscally responsible government
6. Strategic corporate initiatives are advanced through our work with other governments, departments, and stakeholders

What We Believe – Our Values

- Human potential
  Implicit in much of the work that we do in Health and Social Services is a belief in the importance of providing supports and opportunities that enable each person to reach his or her maximum potential – ensuring each of us is empowered to enjoy and participate as fully in life as possible, regardless of our circumstances.

- Individual dignity
  Underpinning the importance we attribute to human potential is a belief that every individual is valuable, worthy of respect, and deserving of ethical treatment.

- Working together
  To make the most meaningful, lasting changes at a societal level, we need to work in an integrated fashion. We are moving to Client/Patient-centred delivery and need to work in partnership with other departments, First Nations and other governments, non-governmental organizations and members of the general public.

- Accountability
  To gain or maintain public trust, we must be prepared to be held accountable for our decisions and activities – to be able to say that we invested resources as wisely as possible based on sound evidence, best practice, and prioritized need.

Department Strategic Context

The Health and Social Services system is a critical priority for our population, providing a continuum of services that preserve and enhance our health and well-being from birth through to the end stages of life. Together with our partners, we strive to ensure that all Yukoners, including those who are economically or socially vulnerable, are cared for, protected and supported in achieving optimal mental and physical well-being.

As the department charged with managing these systems for the people of Yukon, Health and Social Services faces the challenging role of ensuring the services delivered are safe and of the highest quality; that access is appropriate; and that cost growth is sustainable with maximum use of limited resources. With pressures mounting from all directions, this role is increasingly difficult, and it is clear that changes are needed within and beyond the system.

Public health expenditures across Canada have seen extensive growth in recent decades, consuming progressively large shares of provincial and territorial budgets. Yukon is no exception, with the Health and Social Services budget tripling over the past 15 years – far surpassing the rate of population growth in the territory. Competing needs of other departments; economic uncertainty at home and internationally; fluctuating resource prices and increased restraint at the federal level warrant concern and action over cost growth for health and social services. At the same time, demographic changes; advancements in technology; public expectations of service availability and timeliness; and competition for increasingly scarce and costly human resources increase demands on the budgets of health and social services locally and across the country.

Population aging has been frequently highlighted as a driver of cost growth in Health Care. While in fact, the impacts of aging have been less significant than a number of other drivers in Yukon so far, we are anticipating significant growth in the senior population in the coming years. And, as more of our population reaches the oldest age groups, for whom per capita costs are particularly intense, we may expect aging to play an even more important role in driving demands on the health system.

Advances in diagnosis and treatment through improvements and innovation in technology and pharmaceuticals are welcomed for their potential to improve outcomes and quality of life. These advances, however, do not come without a cost and are among the pressures driving our bottom line upward. In Yukon, as in other small jurisdictions, we are particularly vulnerable to the impact of high cost items, making the budget for some aspects of care difficult to control and predict. While we continue to ensure access to the best in proven technology and pharmaceutical treatment, we need to look at how to manage overall costs while leaving room for new and unexpected expenses.

Demographic shifts and increased competition for human resources add to the challenges faced by Health and Social Services. Many employees within the department are approaching or have reached retirement, increasing the need for succession planning, recruitment efforts and training. Several family physicians have retired in recent years, and of those still practicing, more than a third are over 50 years old. Competition for health human resources – including physicians, nurses and allied professionals – is fierce.

While much of the public discussion and research is around pressures on the Health system, the Social Services sector is not immune to the impacts of demographic changes, budgetary constraints, changes in practice and more. Many Yukoners continue to require support in meeting basic needs. Substance abuse (including alcohol and tobacco) and other risk behaviours are still prevalent in our population – sustaining the need for addictions services along with those services that address the social impacts of addictions on families and communities. We may expect increased demand for social services that specifically address the needs of seniors in the coming years, while essential services for families, children and youth will continue to require significant investment of financial and human resources.

Among Patients and Clients, there is a growing recognition that the siloed approach to delivering health and social services is less than optimal. Patients and Clients increasingly expect seamless, integrated services delivered by teams of health and social service professionals. Service delivery is changing its focus – orienting around the needs of Patients and Clients, rather than around existing structures and organizational barriers.

The growth and advancement of technological solutions, including Telehealth and remote monitoring and diagnostic tools, are enabling implementation of new models beyond urban centres, allowing for coordinated, team-based care in rural and remote settings as well. In addition to improving the Client experience, coordinated and integrated care can lead to better outcomes for Patients, Clients and families.

Beyond the move towards integrated service, change is needed and planned at a much broader level for Health and Social Services. Current models of health and social service delivery are neither sustainable nor appropriate for the new realities, and the future will require us to do business differently. A slight adjustment or two to our programs and services will not be enough…a 'transformation' is required. We need a system that is able to continually evolve – one that is aligned with current and future realities, is needs-based, yet flexible and adaptive enough to address emerging challenges and opportunities.

The recently released Clinical Services Plan is one decision making tool that will help guide this evolution – providing a foundation of data that will be updated and monitored to ensure plans and decisions are based on the best and most current evidence. The data collected to date add to the weight of evidence pointing to the need for innovative service delivery; system change and integrated services; as well as appropriate access for rural and remote residents. Services need to meet the needs of Clients and populations across the continuum, while still addressing the most acute and urgent needs on which we have traditionally focussed much of our effort. Patient and Client Safety remains a key priority in this era of transformation and innovation. Efficient, effective services that are aligned with best practices will be essential to moving forward – ensuring we meet our aims of quality service, equitable and appropriate access, and improved sustainability.

In addition to the system itself, we need to look at other factors that impact health and well-being – as individuals, in families, in communities and in our environment. Factors such as income, housing, food security, education, early childhood experiences, employment, and social support systems and inclusion in communities have a profound effect on individual health and well-being. They can directly impact on an individual's physical health, personal health practices, life choices and resiliency. At every stage

of life, health and well-being are determined by complex interactions between social and economic factors, the physical environment in which people live and individual behavior.

All Yukoners have a role to play in optimizing the well-being of our population, our families, and ourselves, and in improving the sustainability of our valued health and social services. As individuals, we can work on making better choices and can seek supports in doing so, when needed. As families, we can strive to provide the best possible start in life for our children and ongoing support for all of our family members. As communities, we can encourage wellness; we can welcome those who have historically been excluded into our fold; we can provide opportunities for meaningful connections among citizens of all ages.

This plan lays the foundation for the evolution of health and social service delivery in the Yukon Territory over the next 15-20 years, while focusing on the goals and objectives for the first five years. We believe that by working with our partners and stakeholders and taking a capacity-building approach, with both a targeted and broad population focus, we will create a quality, adaptive, integrated, and accessible continuum of care and services… Working together with our partners and citizens, we will come ever closer to achieving our vision of 'healthy communities – wellness for all.'

Strategic Goals

This section discusses our strategic goals and outlines the objectives we have identified to realize them.

Department Strategic Goals

Strategic Goal 1 – Optimal physical and mental wellbeing

We all want to see reductions in chronic disease; fewer serious injuries and more Yukoners feeling mentally and physically well, resilient and able to participate fully in life. We want to see appropriate use of acute and urgent health and social services, leaving more of our resources available for enhancing our lives and communities. Our department has a clear role in promoting healthy behaviours and treating conditions and injuries that do arise. But we all have a responsibility to look at the choices we make – to consider how we might reduce our risks of illness and injury, and enhance our lives and those of our families and communities.

More and more we understand that physical and mental wellness can be greatly impacted by our lifestyle and community. Choosing to eat a healthy diet and to exercise regularly can reduce our risk of chronic physical and mental illness. Minimizing risky behaviours by avoiding substance abuse; not smoking; having healthy sexual practices and wearing helmets when cycling or off-roading are other examples of how we can reduce the likelihood of serious injury or illness throughout our lives. Encouraging positive choices and forging strong connections can help build healthy, resilient and thriving communities, further reinforcing our ability to be well and choose wisely.

Our department has a number of initiatives under way that aim to identify where we might adjust our approach to wellness, to better serve our populations in all Yukon communities. We are examining policies and practices related to the whole spectrum of mental health and addictions services for children and youth, and for the population in general. We are working on increasing access to mental health and other services, with continued work on early intervention as well as on integrated delivery of services in the communities. In addition, our ongoing efforts in health promotion, risk reduction and family supports could all be contributors to improved wellness.

To accomplish this we have identified the following objectives:

1.1 Reduction in high-risk behavior

While Yukoners make many positive choices, we know that there are areas in which many of us continue to take unhealthy risks. We continue to see high rates of serious injury, leading to hospitalization or death. We have higher rates of smoking than in many other parts of the country. Substance abuse and addictions impact many of our residents and may often accompany or compound mental health challenges. Contextual factors play a role in influencing our ability and opportunities for making healthier choices. Together, however, families and communities can work to identify and understand high-risk behaviour and when needed, we can seek out and offer supports that empower change.

In the next five years, Health and Social Services will work with other departments and with communities to raise awareness about risks associated with certain behaviours, and will provide supports to enable people to make better choices in these and other areas. Decreased injury rates, prevention or delay of the onset of chronic disease, and reduced complications associated with existing chronic disease are among the benefits we can enjoy by reducing our risk-taking behaviours. In addition to our broader work, we'll have a particular focus on youth, so we can help discourage the establishment of certain risky habits or behaviours before they become entrenched.

1.2 Increase in health promoting behaviors

Maximizing the well-being of residents so they can live full, active lives requires more than a reduction in risky behaviors. Collectively, we need to give children the best possible start in life, equipping them with tools to help them to succeed in making positive choices, in building healthy relationships, in school and on into adulthood. Our department also has a role in this area. Working with families, we'll offer support, services and information to contribute to children's health and development. Family and community supports will also be enlisted more broadly – empowering communities to work together in establishing the healthy environments and strong social connections that will be key to making progress in health promotion across the age spectrum. We all have a part to play in building healthy families and communities.

Given increases in the share of seniors among our population, and in our awareness that most seniors wish to stay in their homes for as long as possible, we'll also be working with older adults and communities to try to maximize the years spent in good health in the community. This means encouraging older residents to stay active and social, and to have healthy habits in all areas of life; providing respite and guidance for informal supports; and maintaining home care and other services that help ensure seniors are safe and secure in their homes. The benefits of extending years spent in good health go beyond increasing the years spent at home. Seniors who have been active, healthy and social may be less likely to suffer from chronic disease or injury and better able to recover from and cope with illness and injury that does occur.

1.3 Increased public protection from exposure to environmental risks that affect health

Healthy populations do not exist in a vacuum. Our surrounding environment can impact our health, both positively and negatively, and our department has a role to play in monitoring, and where appropriate, influencing those impacts.

We will work both within our department and with other government departments in ensuring that appropriate consideration is given to health concerns when relevant policies, programs or projects are initiated. We will work to protect the public from identified risks associated with those activities, as well as from more localized risks such as contaminated well water. We will continue to monitor and plan for potential public emergencies, striving for minimal harm to residents' health in the wake of such an event.

1.4 Reduced impact and incidence of chronic disease

While any level of smoking is a concern, we know smoking is particularly prevalent among our population compared to much of the country. We also continue to see evidence of a high rate of alcohol abuse. Along with genetic predispositions and other factors, smoking and using alcohol in excess are among the most important factors associated with numerous chronic conditions – from emphysema and heart disease, to diabetes and cancer.

As a department, we continue to encourage Yukoners to avoid or quit smoking, to use moderation in alcohol consumption, to maintain healthy weights and active lifestyles. We can't make these changes happen, however – while we can provide resources and supports that empower and encourage, each of us ultimately needs to make choices about our own behaviours. Avoiding the adoption of unhealthy habits and making necessary changes will benefit each of us individually, and all of us collectively. From lower costs associated with treatment to reduced impacts on families, workplaces and communities, we can all gain from positive choices that we make.

In addition to taking aim at the prevalence of chronic disease through promotion and prevention activities, we must carry on our efforts to treat and moderate the effects of disease on those already affected, and to reduce the likelihood of secondary disease diagnoses. We know that, just as for the public in general, those with chronic conditions can realize more positive outcomes through healthy habits, and through the adoption of self-monitoring and self-care routines. Integrated, coordinated and seamless services will continue to be part of the response to chronic disease, especially for complex cases that are less readily managed through self-care.

With a particular focus on COPD, Diabetes and Cardiovascular Disease, our department will be working with Patients with chronic disease to provide tools and direction for monitoring and self-management. Again, however, the improvements we aim for will be seen only if those Patients feel empowered and supported to take action themselves; to make choices that will increase their life expectancy, improve their quality of life, and reduce the likelihood of hospitalization. Together, we can work to prevent the onset of complications or secondary disease, so that those of us with chronic conditions can live fully and independently for as long as possible. Our department and health care providers can also work together in enabling Patients to self-identify complications early, before needs become urgent and consequences become more severe.

Reduced prevalence and severity of complications and secondary disease will mean better outcomes for those with chronic conditions, and reduced costs associated with frequent emergency room visits and hospitalization.

Beyond the cost to the health care system, research suggests that chronic disease can impact the economy as a whole, through increased absenteeism and dependency and reduced productivity and spending power.[1]

What Could Get In Our Way – Risk Assessment

Risk:	**Mitigation:**
Inability to effectively align resources with changing priorities may lead to increased acute care spending and generational impact on client health, or perpetuating poor health habits between generations.	We will implement this strategic plan, with ongoing monitoring and evaluation. We will ensure effective management of prioritized programs, including monitoring, measuring and control at the program level.

How We Are Doing – Indicators

- Decrease in % of males and females age 15-24 diagnosed with chlamydia
- Decrease in 18+ population who were current daily smokers
- Decrease in injury hospitalization rate
- Increase in % of up-to-date vaccinations for school entry children
- Maintain or increase the 'physical activity during leisure time' rates
- Maintain or decrease the fall rate in Continuing Care Programs and serious falls/hospital admission rate for those 65 and over
- Decrease in hospital readmission rate and emergency department revisit rate for COPD

[1] Abegunde, Dele and Anderson Stanciole; "An estimation of the economic impact of chronic non-communicable diseases in selected countries"; World Health Organization, 2006; Retrieved from www.who.int/chp/working_paper_growth%20model29may.pdf June 2013.

Strategic Goal 2 – Safety and wellbeing for vulnerable/ 'hard-to-serve' populations and those with complex conditions

The unique needs of some vulnerable groups present challenges. Age, frailty, disability, complex health conditions, mental health issues, addictions and multiple effects of social and economic disadvantages can result in these groups either not accessing services, or existing services not being a good match.

Individuals who fall into these vulnerable groups may create added pressure for their families and communities. When this happens they often default to higher level, more acute services than they would otherwise require. It is widely accepted that most health and social services should have flexibility to serve the majority; however it must also be recognized that certain groups will 'fall through the cracks' if there are not targeted approaches.

The design of the system itself may be one reason some of us do fall through the cracks currently. For decades, Patients and Clients have been expected to navigate across various service providers, to enter the system at multiple points, and to themselves consider the intersection and overlap between services. This is one reason that we'll be striving for care that is as integrated and collaborative as possible. In-person or virtual teams in both health and social services will work together in understanding and addressing Client needs, rather than addressing each concern in isolation.

To accomplish this we have identified the following objectives:

2.1 Increased access to a range of service options and approaches

Individuals with diverse needs may find it difficult to navigate health and social service systems, or experience a range of barriers to accessing service. This may include 'hard to serve' populations that suffer from a range and combination of cognitive and mental health issues, often compounded by tragic life experiences. Many must enter the system at multiple points to address their needs; their cycle of access to services is typically crisis-oriented. They tend to seek health and social services late,

when more seriously ill or in crisis; require high intensity attention; disappear when stable; and reappear when in crisis once again.

A key goal for our department is to ensure that "any door is the right door" for all Clients and Patients, including those facing a complex mix of conditions and circumstances. We will be more persistent in reaching out to those Clients who face barriers in accessing service. Across our department's range of health and social services, we'll be establishing coordinated case management, and integrated, team-based delivery of services. Person-centred cooperative planning with individuals and their community support systems creates a wrap around, collaborative model and increased stability, and establishes a continuum of care to help Clients access supports before a crisis is underway.

2.2 Meaningful independence and inclusion in the community is gained and maintained

Despite the current prosperity that is evident around the territory, we know that there are those whose basic needs are not being met – whether due to gaps in service provision or to barriers preventing access (transportation difficulties, mental health or addictions challenges, etc.). Homelessness continues to be a visible issue in the territory, and beyond those that are visible, there may be many living in unsafe or unsuitable accommodations.

Emergency supports such as the Food Bank, the shelter at the Salvation Army and the Youth Emergency Shelter are vital to the survival of our most vulnerable populations. Social assistance is also available to assist those facing ongoing income or employment challenges in meeting their most basic needs. Ultimately, however, we envision a Yukon where all residents are equipped and empowered to achieve maximum self-reliance, strengthened by meaningful inclusion in and connections with their broader community.

Employment counselling services offer a basic foundation to help persistently unemployed persons gain and maintain meaningful employment. Supplementary income supports help ensure that those who are not able to meet their needs with other sources of income can achieve a reasonable standard of living and participate more fully in society. The anticipated introduction of transitional housing will provide some of those with complex needs an opportunity to access services, tools and skills which will enable an eventual move to stable housing with supports, or

potentially to independent living. The provision of wrap-around, integrated care will help increase stability and reduce crises among Patients, Clients and communities.

Providing supports that will assist our most vulnerable populations in establishing and maintaining housing, self-reliance and healthy community connections is not something we can do alone. In the coming years, we will continue to work with partners in other departments, governments and outside organizations to identify the most pressing issues related to homelessness and poverty. Together, we aim to find and implement effective and realistic strategies to address these issues.

What Could Get In Our Way – Risk Assessment

Risk:	**Mitigation:**
Service delivery models may not allow vulnerable clients to access services	We will work on transition points within the continuum of care; Increase the range of options available for people with substance use issues; Implement initiatives aimed at early intervention; Plan a system of care with stakeholders to ensure wrap-around services; and, monitor the social inclusion assessment tool usage within government.

How We Are Doing – Indicators

- Decrease in # of Emergency Room visits by people presenting with a mental or behavioral disorder related to harmful alcohol use
- Decrease in self-injury hospitalization rate

Strategic Goal 3 – Access to integrated, quality services

Health and Social Services has recently commissioned a Clinical Services Plan, which examines the needs and current service provision in each Yukon community, and identifies a suggested mix of providers accordingly. This plan, and the data that supports it, will help guide the changes we make in our system over the coming years. The needs of the population as a whole, and of each specific community, will be considered (and continually reassessed) in allocating services and ensuring equitable and appropriate access, with a clear emphasis on integrated care.

Integrated care is about structuring services to ensure continuity, co-ordination and appropriate access to quality care that considers the Patient or Client as a whole. For a Client or Patient, service delivery under integrated care is smooth (even when multiple service providers are involved), stress is minimized, and issues or concerns are not considered in isolation. The concept of integrated care closely aligns with the concept of collaborative care – working together to ensure Clients and Patients get the services they need.

Transforming our system to provide integrated care will require many of us to step beyond our traditional professional roles and boundaries. Service providers will be looking at Clients and Patients more holistically – identifying appropriate services that may or may not be directly within the provider's mandate. It may mean assisting the Client in accessing another service, and even travelling with the Client to his or her next service point where stress or other barriers are perceived.

Given our geography and our small, widely distributed population, accessing facilities in Whitehorse and the southern provinces will always be required for some service needs. However, integrated services will also mean linking more care to one's home and community. Virtual care via Telehealth enables access to a range of generalists and specialists in a place where an equivalent care provider may not be present, and where friends and family are nearby. Involving families and community-based service providers in care planning and provision provides an ongoing source of support for those transitioning back from hospitals or other care settings, as well as for those with chronic conditions. Equipping Clients with self-management tools makes each Client part of his or her own care team;

enabling the Client to manage ongoing monitoring and care while continuing to provide access to professional and urgent services when needed.

Over the next five years, we will maintain a strong focus on ensuring that as many Yukon residents as possible are able to access service in an appropriate setting, as close to home as possible; that this setting will provide linkages to multiple services points; and that transitions between providers are smooth and navigable, when required. Innovative service delivery models, including virtual service delivery and the involvement of Clients and communities in care will be among the approaches involved in realizing this goal.

To accomplish this we have identified the following objectives:

3.1 Increased access of services 'closer to home'

When looking at where Yukoners access the services they need, we need to consider what the most appropriate place/delivery method may be for that particular service and that particular person. While travel to larger centres is sometimes necessary, Clients are often best served by accessing services in their home community, where relationships with a care team can be established and Patient information can be housed, and where family and friends are available if additional support is needed. We need to consider innovative and flexible approaches to service delivery to enable community access as much as possible.

In smaller communities, Community Health Centres offer a consistent access point for those needing primary care. The teams of health professionals – whether resident, visiting or virtual – enable a flow of information and establish connections with communities, gaining a better understanding of the individual Patient's needs and the context in which he or she lives.

Our interdisciplinary/transdisciplinary teams, whether working in the same physical location, or joining forces virtually, strive to ensure that Clients are receiving the care they need, in a setting where they feel comfortable, safe and secure. Telehealth services will also be a growing part of service delivery in the communities, ensuring that urgent diagnostic needs and

other services that can be delivered remotely are available to those who live outside the capital area.

Through continued conversations and efforts around an appropriate range of quality community-based services, as well as through an innovative use of technology, we strive to see more Yukon residents accessing care in their home communities. This requires continually evaluating the needs of each community and assessing what might be appropriately and realistically delivered in each community, whether via conventional or innovative delivery methods. In addition to improving equity of access and reducing travel (at the cost of either the Patient or the department), it is anticipated that increased access of appropriate care in the communities could improve Patient outcomes and experiences.

3.2 Improved matching of identified needs and effective services

The Clinical Services Plan provides a foundational set of data that identifies needs at the territorial and community levels. Starting in this next five years, we will be building on this foundation of evidence, to ensure a full and current understanding of needs and that services are aligned to needs as closely as possible.

While physicians will continue to be the most appropriate professionals for delivering care in many instances, part of this work of matching needs to services will involve looking at expanded roles for other types of providers. In addition to continuing to encourage the integration of Nurse Practitioners into the health care delivery system, we are examining the potential for expanded scope and increased use of other health and social service professionals, both in the capital and in smaller communities. Progress in these areas could lead to reduced strain on our physicians and increased access to primary care in community settings. Where in-person access to various professionals is not feasible, this will involve increased use of Telehealth, enabling Patients and Clients to access of a variety of services in a single, community-based setting.

The referred care clinic, which specifically targets a population with complex needs (homelessness, addictions, etc.), is one example of the

benefit of incorporating multiple professionals into a primary care setting and of matching service availability to Client needs. This clinic provides one-stop access to mental health services, physician care and an outreach worker for a high-needs population; a population that may otherwise find accessing appropriate services of this diverse nature to be extremely challenging. The planned incorporation of a nurse practitioner into the clinic will provide increased access to care for a population with limited means for transportation and low feasibility of accessing service through private clinics. Despite the targeted audience for this particular clinic, demonstrated success in this setting may provide a model for expanded use of in-person or virtual teams elsewhere.

Regardless of where care takes place, an emphasis on ensuring smooth transitions between services and service providers (through integrated case-management and transition supports and processes) will contribute to meeting Patient and Client needs, and to the realization of optimal health and wellbeing. From the Patient or Client perspective, reducing their stress and administrative burden, and eliminating as many barriers as possible, will help them maintain access and stability as they age and transition through the care continuum.

Given the large-scale changes involved in many of these initiatives, it will be important to monitor the impacts and to assess whether the results are what we intended. For this and other reasons, the data gathering exercise that formed part of the Clinical Services Plan will be only the beginning of comprehensive data gathering and analysis exercises for our department. Across the department, we are considering ways to better facilitate the collection, retention and use of data to ensure we have the evidence we need to make good decisions.

What Could Get In Our Way – Risk Assessment

Risk:	**Mitigation:**
Service delivery models may not allow clients to access appropriate services at the right time, place, and with the appropriate care/service provider	We will increase the use of technology and innovative approaches in the delivery of care; Implement the Clinical Services Plan; Enable service providers to work to their full capacity and scope through legislation and collaboration; Design the health and social system to promote ease of access and navigation of services; and, improve our ability to identify, capture, and utilize data and evidence to inform system decisions.

How We Are Doing – Indicators

- Increased # of Telehealth surgical/specialist consults which results in reduced medical travel
- Decrease in ambulatory care sensitive conditions rate
- Increased % of HSS youth Clients moving into adulthood with transition plan completed
- Decrease in avoidable mortality from treatable causes rate

Corporate Strategic Goals

Strategic Goal 4 – Talented people are recruited, developed and engaged to provide high quality service to the public

It goes without saying that without a committed, high quality workforce, it would not be possible to accomplish the system-wide changes we are envisioning for the next five years. And, like many government departments, we are expecting to see significant turnover in our department over the next decade. We need to ensure both our long-term staff and our newer workers are valued, developed and engaged if we want to achieve our objectives.

More than one in five of our employees are aged 55 or older, and many of these older workers are long-standing employees holding a wealth of corporate knowledge. We have to work now to preserve this knowledge, both by encouraging those who are approaching retirement to share with and foster younger workers, and by ensuring the right workforce is in place to receive and benefit from this knowledge transfer. At the same time as we ensure this preservation of historical knowledge, we need to inspire our workforce to embrace and build upon the changes we'll be pursuing.

Of course, as a department, we not only take on the task of maintaining and strengthening our own workforce. We are also involved in ensuring that we have a range of quality health and social service professionals to meet the needs of our diverse population. Recent retirements of family doctors in the territory and rural recruitment challenges across the country have highlighted the need to monitor demographic and other pressures in the care provider population (both within the territory and in competitor jurisdictions), and act accordingly.

While we have an important part in physician and other health professional recruitment, this is another area in which we can't achieve our goals in isolation. Increasingly, it is clear that communities themselves have a vital role in recruitment and retention of physicians and other health professionals. Communities are ideally positioned to offer prospective physicians and others an understanding of what their town has to offer.

Recent experience in Northern BC illustrates what might be achieved when a community works together to show the best of what the community has to offer – particularly in areas of interest to each potential recruit.[2] Further efforts in welcoming those who are recruited into the social and professional fabric of the community may greatly increase the chances of retention over the long term.

In the coming five years we'll continue working with our partners, to ensure we have the appropriate mix of providers, and that resident professionals are welcomed and encouraged to stay for the long term.

To accomplish this we have identified the following objectives:

4.1 Increased employee commitment, productivity, and satisfaction

The first step in ensuring that employees are able and eager to work to full scope and maximum potential is to have the right person in the right job at the right time. Each of us has a unique set of skills and experience to offer, as well as having a particular range of interests or activities that engage us most fully. As much as possible, we want to ensure a match between the employee's interests and abilities and the position he or she holds – so each employee is engaged and capable of fulfilling his or her role.

Earlier identification of upcoming vacancies, improvements in evaluating needs and requirements for positions and facilitating knowledge transfer between outgoing and incoming staff will all be part of our work towards this goal. We will also maintain a focus on training and professional development over the next five years, ensuring our employees have the skills and knowledge that they need to perform well, and that they feel supported and encouraged by their employer. Finally, in addition to promoting a work life balance and healthy, active living among our employees, we'll demonstrate an unwavering commitment to safety and health in the workplace through the development and implementation of our Health and Safety Management System.

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[2] Rural Coordination Centre of BC; BC Rural Update; "Communities play key role in physician recruitment, retention – Fort St. James case study"; retrieved from http://rccbc.ca/enews/2013/07/communities-play-key-role-in-physician-recruitment-retention-fort-st-james-case-study/ June 5, 2014.

4.2 Increased alignment between workforce and business objectives

As we implement system changes, the evidence accumulated for the Clinical Services Plan will help not only to ensure the right mix of services are in place in each community, but also to provide a roadmap for human resource planning in the years to come. Meeting the needs of our population in the coming years requires anticipating vacancies and increased demand. Given a limited level of resources, it also means making the best possible choices when allocating positions - ensuring that every employee is in a place where they are most needed, and where their efforts will be most effective.

On an ongoing basis, we'll need to monitor trends in population, health and human resource data. The plan we've established sets us on a path based on current and recent trends, but if and when changes in needs or staffing occur, we need to be ready to act and shift our workforce accordingly. While we are already using a wide range of data to support our decision making, in the coming years we'll be looking at improvements in data collection and analysis, positioning us to make decisions based on the latest and best information possible.

What Could Get In Our Way – Risk Assessment

Risk:	**Mitigation:**
Our inability to recruit, retain, and engage employees over the long term may compromise the achievement of strategic outcomes.	We will implement the Health and Safety Management System; Implement the Clinical Services Plan; Improve our ability to identify, capture, and utilize data and evidence to inform Human Resource decisions; and, enable service providers to work to their full scope as appropriate, and possible.

How We Are Doing – Indicators

- Decrease in total Department annual OT cost
- Increased # of position's PDPs and PPPs completed with aligned training plans

Strategic Goal 5 – Open, accountable and fiscally responsible government

To accomplish this we have identified the following objectives:

5.1 Sound business practices operate to ensure compliance, effectiveness and efficiency

In recent years, there has been a steady increase in the attention and importance given to open, accountable and intelligent business practices in government. As the department entrusted with the task of using public funds to serve the health and social service needs of Yukon residents, it is incumbent upon us to ensure that we are making the best possible use of those funds.

Across government there are new processes in place to ensure procurement is compliant with expected practices, particularly where large investments are involved. Within the department, we are offering additional training to ensure that employees involved in procurement are following proper procedures; we are improving our planning processes for capital projects; and we continue to maintain our high standards for timely and accurate financial transactions and record management.

Improvements in our planning process will help us make wise investments with our budget. The wealth of information gathered in developing the Clinical Services Plan gives us the advantage of a robust starting point. Going forward we are committed to keeping these data fresh; to filling in information gaps that remain; and to use these data to inform wise and effective decisions. Serving the needs of the Yukon population will mean not only identifying and responding to existing health needs, but also

investing in efforts that will slow the growth of health and social service costs in the territory.

Working with partners such as the First Nations, Yukon Hospital Corporation, physicians and other providers, we'll be identifying the most efficient and effective methods and service providers for meeting the population's needs. Health promotion and prevention activities, increasing the mix of service providers, and reducing the need for medical travel will also be among the strategies contributing to management of cost growth.

While containing costs is crucial, we also need to ensure that our investments are wisely made, and that they are having the intended impacts. We are embarking on a new era of monitoring for outcomes, so we will be better able to identify when something is working very well or less than optimally. This will allow us to expand on or learn from tools and techniques that are working well, and to adjust or redirect efforts when our work is not having the intended impact.

The ever-increasing share of provincial and territorial budgets consumed by health care, and the noted budgetary, technological, demographic and other pressures mean effective and efficient business practice is more important than ever. Endlessly diverting more of our overall government budget to respond to these pressures is not an option – we continue to need (and want) investments in highways, schools, and other important infrastructure and programming. Our department will continue to work with partners and communities towards containing growth in costs, while concurrently ensuring investments are made wisely and effectively, with continual monitoring and adjustments to plans when appropriate.

5.2 Systems and infrastructure are in place to meet Client service needs and improve outcomes

Delivering on the objectives we've identified, as well as meeting the ongoing service needs of Yukoners, will not be possible without a sound infrastructure as a foundation. Our department must balance the need for investment in repairing, replacing or upgrading systems and infrastructure with the ongoing spending needs of vital health and social services. This balance requires careful planning and prioritization – looking at what we need to do now, and what we need to plan for over the long term.

In conjunction with the department of Highways and Public Works, we'll continue to work on a long term plan - identifying and prioritizing necessary upgrades and additions to our information systems, capital and equipment. Rather than reacting to needs only as they become urgent, we'll establish a realistic and appropriate schedule for upgrades, maintenance and replacement that aligns with our priorities and service planning. We'll also be looking across the department rather than working in isolation, so we can build information systems that work together, and so we can capitalize on any opportunities for shared improvements and efficiencies.

Along with potential expansion of online services for Yukon residents, efforts and investment in technology and information systems will help us establish innovative solutions to challenges of access, particularly for our smaller and more remote communities. Along with best practices in health and social service provision, these innovations will mean improved outcomes and more equitable access for our population, both in central and remote locations.

What Could Get In Our Way – Risk Assessment

Risk:	**Mitigation:**
Insufficient infrastructure and systems may impede the achievement of expected service outcomes	We will work to streamline and modernize information systems; and ensure an ongoing review of our priority infrastructure and information system needs

How We Are Doing – Indicators

- Increased # of appropriate and accurate variances
- Increased # of Branches/programs with improved performance measures

Strategic Goal 6 – Strategic corporate initiatives are advanced through our work with other governments, departments, and stakeholders

To accomplish this we have identified the following objectives:

6.1 Maximized opportunities for partnering with other governments, departments, and stakeholders

In order to ensure an accessible, effective, efficient system, we have to maximize our opportunities to work with other Yukon government departments, Yukon First Nations, physicians, non-governmental organizations and federal departments. The myriad factors that influence health and well-being clearly indicate that our department and its goals cannot be separated from the work and goals of our partners.

We collaborate and consult with First Nations Health Directors and leadership on a regular basis, to ensure that both the needs of First Nations populations and the capacity of First Nations health and social service professionals are recognized and considered in service planning and delivery. We want to maximize partnerships with First Nations, ensuring we as a department and as a population are making the best use of the capacity the First Nations service providers have to offer.

We'll work with Yukon Housing Corporation in developing and moving forward on a housing action plan that addresses a broad spectrum of housing needs. We'll be engaging other government departments in implementing policies and tools that support both Social Inclusion and Wellness. And, we'll continue to support non-governmental organizations that provide essential services that meet a variety of needs.

What Could Get In Our Way – Risk Assessment

Risk:	**Mitigation:**
Ineffective collaboration prevents the Department from maximizing opportunities	We will support First Nations to develop service delivery capacity; and ensure we are engaged in our partnerships with First Nations and other governments to enhance and ensure effective program delivery.

How We Are Doing – Indicators

- Increased # of cross-department partnerships/initiatives