



Annual Report 2016-2017

Transforming Health Care
Across North Simcoe Muskoka

**Healthy People
Excellent Care
One System**

North Simcoe Muskoka Local Health Integration Network Annual Report 2016-17 Table of Contents

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2016-17 NSM LHIN Financial Statements

Message from the Board Chair and Chief Executive Officer

In the 2016-17 fiscal year, the North Simcoe Muskoka LHIN continued to build upon achievements to date aligned with the strategic priorities outlined in the LHIN's 2016-2019 Integrated Health Service Plan:

- Improve Access to Appropriate Care
- Build Capacity and Enhance Coordination
- Drive System Sustainability.

We continued to value and be responsive to the needs of residents, clients, family members, health service providers, communities, and other stakeholders through extensive community engagements with residents of North Simcoe Muskoka.

In addition, during 2016-17, our LHIN undertook the complex work of preparing to expand our structural responsibilities with the transfer of North Simcoe Muskoka Community Care Access Centre staff and services.

The North Simcoe Muskoka LHIN is proud to be a partner in enhancing access to quality care by working with many partners from health care and beyond. This annual report highlights some of our achievements by working in partnership to put patients first:

- Improved system navigation and health equity through the development and funding of both a French Language Services Navigator and an Aboriginal Patient Navigator
- Investments in mental health and addiction services for the Assertive Community Treatment team which provides support to those living with mental health illness and Skills for Safer Living which supports individuals who have attempted suicide
- Expansion of community-based care through the transitional bed program, providing assisted living and care coordination
- Development of the Muskoka and Area Health System Transformation Council as a step in developing an integrated care model for the Muskoka sub-region
- Engagements with clients, caregivers, families, providers and stakeholders through a wide range of community events including our annual forum which concentrated on our relationship and partnership with our local aboriginal community members

In addition to these achievements, we were honoured this past year with two groups in our LHIN being recognized for the Minister's Medal Honouring Excellence in Health Quality and Safety. Leah Bergstrom won the Individual Champion award for her work as an Aboriginal Patient Navigator with the Simcoe Muskoka Regional Cancer Program. An honourable mention was awarded to Better Coordinated Cross-Sectorial Medication Reconciliation (BOOMR) for their work ensuring patient safety through medication management when transitioning care.

On behalf of the NSM LHIN and its Board of Directors, we would like to thank our staff, health service providers, community service organizations and the community for ensuring that the residents of North Simcoe Muskoka continue to receive high quality care. We look forward to continuing to work with the members of our communities to inform health service planning and improving access to care.



Robert Morton
Board Chair



Jill Tettmann
Chief Executive Officer

Healthy People. Excellent Care. One System.

North Simcoe Muskoka LHIN Board of Directors



Robert Morton
Chair
Tay Township
Term: June 9, 2011 - June 8, 2017



Barbara Dickson
Vice-Chair
Orillia
Term: April 15, 2015 - April 14, 2018



Margaret Redmond
Vice-Chair
Tiny Township
Term: April 18, 2011 - April 17, 2016



Peter Preager
Wasaga Beach
Term: April 18, 2011 - April 17, 2017



Ellen Mary Mills
Collingwood
Term: September 8, 2014 - September 7, 2017



Ewelina Chwilkowska
Orillia
Term: November 2, 2016 - November 1, 2019



Andreas Ott
Tay Township
Term: March 1, 2017 - February 28, 2020



Larry Saunders
Huntsville
Term: February 10, 2016 - February 9, 2019



Ron Stevens
Barrie
Term: May 17, 2011 - May 16, 2017



Ernest Vaillancourt
Minesing
Term: December 9, 2015 - December 8, 2018



Tim Withey
Huntsville
Term: March 1, 2017 - February 28, 2020

Introduction

Together with our health service partners, the North Simcoe Muskoka Local Health Integration Network (NSM LHIN) establishes priorities and plans for health services delivered in North Simcoe Muskoka (NSM). The LHIN also provides system leadership, spurs change and fosters collaboration among all health system partners, including health service and primary care providers and public health professionals.

In 2016-17, the North Simcoe Muskoka (NSM) LHIN funded 61 health service provider organizations to deliver services across the continuum of care. Several of these organizations have multiple homes, programs or branches in NSM, which brings the total to 71. We allocated approximately \$850 million to the following local health system organizations:

- 7 Hospitals
- 1 Community Care Access Centre
- 26 Long-Term Care Homes
- 3 Community Health Centres
- 27 Community Support Service Organizations
- 7 Community Mental Health Agencies

Fiscal 2016-17 was the last year that LHINs did not directly provide health care services. However, during this time, NSM LHIN prepared for the expansion in our structural responsibilities to deliver higher quality care in an integrated and timely manner, with the transfer in 2017-18 of North Simcoe Muskoka Community Care Access Centre (CCAC) staff and services. This involved complex work streams to transfer the CCAC to the LHIN, establishing sub-regions, and enhancing our governance.



Vision – Healthy People. Excellent Care. One System.

NSM LHIN's **System Transformation Model** works from the inside out, migrating toward a vision of **Healthy People. Excellent Care. One System**. It is the foundation upon which **Care Connections – Partnering for Healthy Communities** has been designed and identifies the common vision NSM LHIN's health system partners are committed to achieving.



Healthy People

At the centre - the heart - of NSM's health system are its people; almost 480,000 people. Represented by six overlapping circles, the health needs of our population – social, occupational, spiritual, physical, intellectual, emotional, environmental, financial and mental wellness – are diverse and forever changing as they move through life and stages of health.

Excellent Care

Safe, quality person-centred care will provide the right care at the right time and in the right place. It will be achieved through **Care Connections**, which organizes health services into six clinical areas (blue – Complex and Chronic Health Needs; In-Home & Community Capacity; Maternal, Newborn, Child & Youth Health; Mental Health & Addictions; Medicine; and Surgery), in turn supported by six key enablers (orange – Communications & Community Engagement; eHealth; Governance; Integrated Health Human Resources; System Navigation; and Transportation) that help to fundamentally support the activities of each clinical area.

One System

Through **Care Connections**, health system partners and residents across NSM have come together committed to optimizing the use of our collective resources to promote a healthy and supportive environment, to take care of people when they are ill and to help them maintain better health through all stages of life.

Mission – Together Achieving Better Health, Better Care, Better Value

Care Connections - Partnering for Healthy Communities is the 10-year operational roadmap designed to bring about the vision of an integrated health system across the NSM LHIN. Working within its framework, health system partners and communities across the region are committed to the development and implementation of effective, collaborative strategies, designed to improve service delivery and contribute to the needs and well-being of those we serve.

In the NSM LHIN, it is recognized that transformation of the health system is the shared responsibility of many partners across the continuum of care including residents, people with lived experiences, their families and health care professionals. Through **Care Connections**, everyone takes ownership of their health system.

Care Connections makes a bold prediction: by working together, we can make the local health system work better. This means coordinating services, managing information and ensuring people move effortlessly from one level of appropriate care to the next in a timely fashion. It requires transforming an “old system” that was prone to duplication, waste and inefficiencies, to a “new system” that is sensible, sustainable, and coordinated effectively to meet the health needs of its residents.

Collaboration with health system partners, to share accountability and take collective ownership for health system transformation, has already led to:

Healthy People = Better Health		improved health of the population: quality person-centred care meeting local needs.
Excellent Care = Better Care		better experiences for the individual: accessible, well-coordinated and sustainable care.
One System = Better Value		efficient operation and sustainability: local healthcare dollars being spent wisely and appropriately.

North Simcoe Muskoka LHIN Profile

The NSM LHIN covers an area of 8,445 square kilometres and was home to 479,471 residents in 2015, making it the second smallest LHIN in terms of total population. NSM includes five sub-regions. These sub-regions have been the foundation of community planning for many years in the region. The Ministry of Health and Long-Term Care approved slightly realigned NSM sub-region boundaries in 2016-17 to better reflect patient access patterns. These five approved sub-regions are as follows:

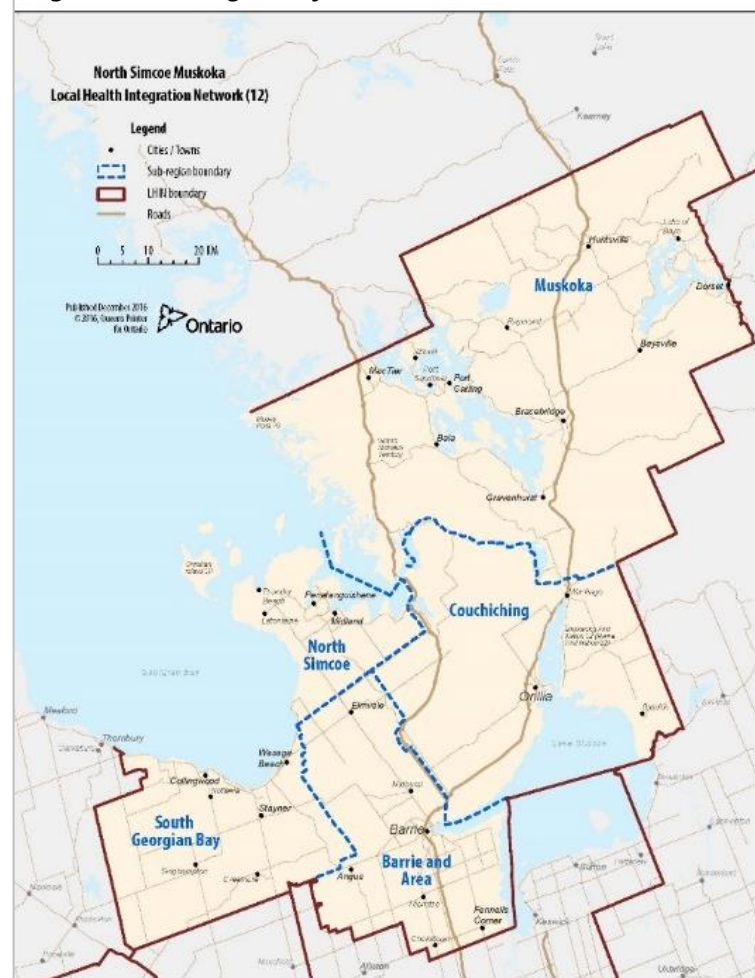
- **Barrie and Area**
- **Couchiching** (previously referred to as Orillia and Area)
- **Muskoka**
- **North Simcoe** (previously referred to as Midland Penetanguishene and Area)
- **South Georgian Bay** (previously referred to as Collingwood, Wasaga Beach and Area)

Between 2015 and 2025, the population in NSM is expected to increase by 10.7 percent, which is comparable to projected growth for Ontario overall.¹

A large majority of NSM residents identify English as their mother tongue (90.2 percent), with the second most common language being French (2.8%).¹ Among the five sub-geographies, the North Simcoe sub-region has the highest proportion of residents who reported French as their mother tongue (7.4 percent).² Of note, very few residents in the region reported no knowledge of either English or French (0.3%).¹

According to recent census data, 4.3 percent of NSM residents identify as Aboriginal, which is the third highest proportion among the 14 LHINs.¹ In addition to those who live off reserve, Indigenous people reside in four First Nations Communities within the region: Beausoleil First Nation, Chippewas of Rama First Nation, Wahta Mohawks First Nation, and Moose Deer Point First Nation. Among the five sub-geographies in NSM, the North Simcoe sub-region is home to the largest proportion of residents who identify as Aboriginal.² The significant Aboriginal population in the region is an important planning consideration as Aboriginal Peoples in general experience a greater burden of morbidity and mortality than non-Aboriginal Canadians.³

Figure 1: Sub-regions of North Simcoe Muskoka LHIN



¹ Ministry of Health and Long-Term Care Health Analytics Branch. Environmental scan integrated health service plans 2016-2019. Ministry of Health and Long-Term Care; 2015.

² Ministry of Health and Long-Term Care Health Analytics Branch. Health Link demographic census and utilization profile. Ministry of Health and Long-Term Care; 2013.

³ Garner R, Carriere G, Sanmartin C and the Longitudinal Health and Administrative Research Team. The health of Inuit, Metis and First Nations adults living off-reserve in Canada: the impact of socio-economic status on inequalities in health. Statistics Canada; 2010.

Reducing these disparities is key to ensuring health equity for the First Nations, Métis, and Inuit (FNMI) residents of NSM.

NSM currently ranks in the top three LHINs in terms of its relative proportion of seniors aged 65 and older. In 2015, seniors represented 18.8 percent of the NSM population. As is the case in other regions across the province, forecasted growth for seniors greatly exceeds that of other age groups. This means that those aged 65 and up are expected to account for 21.3 percent of the population by 2020 and 24.3 percent by 2025.⁴ This demographic shift has significant implications on the delivery of health care services in the region.

Nearly one-third (32.0 percent) of NSM residents live in a rural area, making the region home to the third largest proportion of rural residents in the province.⁴ NSM's large rural population is notable given that findings from a pan-Canadian study of rural health show a significant urban-rural gap on a number of health-related measures, including both risk factors like smoking and obesity, and outcomes, such as mortality from injury and certain chronic diseases.⁵

Table 1 - NSM LHIN Population Characteristics

	NSM LHIN (%)	Ontario (%)
Population aged 65 and up	18.8	16.1
Population aged 75 and up	8.2	7.1
Population English mother tongue	90.2	70.4
Population French mother tongue	2.8	4.4
Population Aboriginal identify	4.3	2.4
Population rural residents	32.0	14.1

Health and Health System Utilization

Access to Appropriate Levels of Care

Primary care access is key in ensuring that patients receive care in the most appropriate setting for their needs. Local data on primary care attachment includes both a patient self-report measure and a measure of continuity in primary care utilization. According to data from the Canadian Community Health Survey, approximately 96.5% of NSM adults report having access to a regular medical doctor.⁶ By contrast, an analysis of utilization data indicates that 87.4% of NSM residents are either attached to a primary care physician or Nurse Practitioner-Led Clinic (NPLC), or are regularly accessing the same family physician.⁷ Regardless of how it is measured, this equates to a large majority of NSM residents being attached to a primary care provider.

⁴ Ministry of Health and Long-Term Care Health Analytics Branch. Environmental scan integrated health service plans 2016-2019. Ministry of Health and Long-Term Care; 2015.

⁵ DesMeules M, Pong R, Lagacé C, Heng D, Manuel D, Pitblado R et al. How healthy are rural Canadians? An assessment of their health status and health determinants. Canadian Institute for Health Information; 2006.

⁶ Health Analytics Branch. Environmental scan integrated health service plans 2016-19. Ministry of Health and Long-Term Care; 2015.

⁷ Internal analysis up to March 31, 2016 based on Corporate Provider Database (CPDB), Claim History Database (CHDB), Registered Persons Database (RPDB), Client Agency Program Enrolment (CAPE). Accessed June 2016.

Despite the high primary care attachment rate, utilization of NSM emergency departments (EDs) for less urgent / non urgent conditions and for conditions better treated in a primary care setting exceed those of the province. Based on 2016-17 data, the rate of ED visits for CTAS IV and V conditions best managed elsewhere was 6.27 per 1000 population.⁸ Data also shows that local patients frequently remain in hospital while awaiting placement in a more appropriate setting, which is reflected in the alternate level of care (ALC) rate. ALC is monitored by two different means: Percent ALC Days and ALC rate. Percent ALC Days is calculated when patients who have been designated in need of ALC are discharged. The percent ALC Days for the first three quarters of 2016-17 was 18.07%, down from 23.83% for fiscal year 2015-16. This, in combination with an overall lower ALC rate of 14.47% for fiscal year 2016-17, indicates an overall improvement in ALC within NSM LHIN.

Aging Population

NSM currently ranks in the top three LHINs in terms of its relative proportion of seniors aged 65 and older, which has significant impacts on the delivery of health care in our region. Data from the Canadian Institute for Health Information shows that seniors are high users of the health care system, including the hospital, continuing care, home care, and primary care sectors.⁹ Provincial data shows a clear association between older age and the rates of both scheduled and unscheduled emergency department (ED) visits and ED visits for potentially preventable conditions.¹⁰ Between 2010 and 2012, seniors accounted for approximately 22.4% of all NSM emergency department visits.¹¹ Seniors also account for a significant proportion of patients designated as ALC; based on 2015-16 data, seniors aged 65 and older accounted for 85% of patients who were in acute care and designated ALC long waiters (ALC lengths of stay greater than 30 days).¹²

Complexity and Chronic Disease Prevalence

Data indicates that the prevalence of chronic disease in NSM is the second highest in the province and that the rate of multiple chronic conditions is increasing over time. Specifically, in 2013, 43.5% of NSM residents reported having a chronic condition and 18.3% reported having multiple chronic conditions. High blood pressure is the most prevalent chronic condition in the region, followed by arthritis and asthma. Related to this are high rates of health system utilization and increased rates of mortality. Relative to the province, residents of this region had higher rates of both hospitalization and mortality from cancer, COPD, diabetes, ischemic heart disease, and stroke. Further, in this region, nine chronic conditions accounted for more than 60% of all deaths and nearly a quarter of acute hospitalizations in 2013.¹³

Based on the Ministry of Health and Long-Term Care's definition, a patient is identified as being complex and chronic if that patient has three or more comorbid chronic conditions. Based on internal analysis of 2013-14 data, the largest proportion of chronic and complex patients in NSM are those between 75 and 84 years of age. However, the prevalence of chronic and complex

⁸ North Simcoe Muskoka LHIN. Ministry-LHIN quarterly stocktake report, November 2016. NSM LHIN; 2016.

⁹ Canadian Institute for Health Information. Health care in Canada 2011 – A focus on seniors and aging. CIHI; 2011.

¹⁰ Bronskill SE, Carter MW, Costa AP, Esensoy AV, Gill SS, Gruneir A et al. Aging in Ontario: an ICES chartbook of health service use by older adults. Institute for Clinical Evaluative Sciences; 2010.

¹¹ North Simcoe Muskoka LHIN Seniors Strategy Task Group. Strategy for a specialized geriatric services program in North Simcoe Muskoka. North Simcoe Muskoka LHIN; 2014.

¹² Access to Care. North Simcoe Muskoka LHIN monthly alternate level of care performance summary, December 2016. Cancer Care Ontario; 2016.

¹³ Ministry of Health and Long-Term Care, Health Analytics Branch. Environmental scan integrated health service plans 2016-19. Ministry of Health and Long-Term Care; 2015.

conditions begins to increase after the age of 55. Among chronic and complex patients in NSM, the top five most prevalent conditions are hypertension, diabetes, ischemic heart disease, arthritis disorders and pneumonia.

Mental health and addiction conditions are included in the Ministry's definition of chronic disease. Utilization rates for designated mental health beds among NSM residents are among the highest in the province. Specifically, in 2013-14, the rates of active cases, admissions and discharges per 100,000 population among NSM residents were the second highest in the province. This is consistent with the overall trend of higher utilization rates in LHINs with tertiary psychiatric beds, and may reflect the drift of individuals with severe persistent mental illness to regions with specialized resources. Among active cases in NSM LHIN hospitals, short stay, mood disorders, and schizophrenia / psychotic disorders accounted for the largest proportions of patients. Emergency department utilization for mental health and substance abuse conditions in NSM is, however, well below the provincial average, which may reflect recent efforts to implement community based approaches to care in the region.¹⁴ The exception to this is emergency utilization for children and youth with mental health or addiction conditions. In 2014-15, the NSM LHIN had the third highest ED visit rate in the province for children and youth with a primary diagnosis of mental health or addiction, which may reflect the lack of inpatient mental health services for children and youth at that time.¹⁵ This gap has been addressed through the Ministry's recent investment in a regional Child and Youth Mental Health program for NSM.

Palliative and End-of-Life Care

Palliative care patients are more likely than other types of patients to be designated as ALC. Specifically, 14.7% of palliative care patients in the province had at least one ALC day in 2010-11 compared to 5.4% in other patients. In NSM, 21.5% of palliative patients had at least one ALC day versus 6.6% in other patients. This is of particular importance given the high rate of ALC utilization in the region.¹⁶

Ministry and LHIN Initiatives

In consultation with patients, health service providers and other stakeholders, the NSM LHIN considered the following four strategic goals of the *Patients First: Action Plan for Health Care*¹⁷ in the local context:

ACCESS	Improve access – provide faster access to the right care
CONNECT	Connect services – deliver better coordinated and integrated care in the community, closer to home
INFORM	Support people and patients – provide the education, information and transparency they need to make the right decisions about their health
PROTECT	Protect the public health care system – make decisions based on value and quality, to sustain the system for generations to come

¹⁴ North Simcoe Muskoka LHIN. Ministry-LHIN quarterly stocktake report, February 2017. NSM LHIN; 2017.

¹⁵ Royal Victoria Regional Health Centre (RVH) analysis of 2014-15 National Ambulatory Care Reporting System (NACRS) and 2013 Ministry of Finance data. Accessed July 2016.

¹⁶ Ministry of Health and Long-Term Care. Analysis based on 2010-11 data extracted from the DAD. MOHLTC; 2012.

¹⁷ Office of the Minister, Ministry of Health and Long-Term Care. Patients first: action plan for health care. Ministry of Health and Long-Term Care; 2015.

The result of the analysis of local needs in the context of provincial direction led to the identification of three strategic priorities for the NSM LHIN's 2016-19 Integrated Health Service Plan:

-  **1.0 Improve Access to Appropriate Care**
-  **2.0 Build Capacity and Enhance Coordination**
-  **3.0 Drive System Sustainability**

From these three strategic priorities, the Annual Business Plan for the NSM LHIN was developed. The priorities of the NSM LHIN and the goals that cascade from them reflect both the strategic goals of Patients First and the priorities of the Ministry of Health and Long-Term Care. These priority areas include home and community care, relationships with primary care and public health, community based planning and integration in geographically defined sub-regions, expanded digital health, and capacity building. Equity, quality, community engagement, collaboration and patient centred care continue to be a lens for work now and in the future.

The following is a progress report on the NSM LHIN's priorities, and achievements of fiscal year 2016-17:



Goal 1. Improve Access to Appropriate Care

ALC Review

The NSM LHIN initiated a region-wide ALC review in 2015-16, including stakeholder interviews, a review of data, a retrospective chart audit, and a review of both ALC long stay outliers and patients with behavioural needs. The review resulted in 24 recommendations addressing discharge planning, communication, education, advocacy, standardization, resources, and home care. NSM's ALC Steering Committee was kicked off in the fall of 2016 and is intended to provide system oversight on the implementation of the recommendations as well as leading the change management process. An ALC Standardization Task Force was also established to support implementation of recommendations aligned with the development and adoption of regional standards. Two remaining proposed working groups, Information Technology and Legal Advisory, will be addressed in future years.

Telemedicine

Telemedicine is an ongoing area of focus within NSM, with quarterly performance monitoring taking place using customized NSM reporting templates and clear accountability agreements. In August 2016, funding was reallocated from a program that was closing and divided between two programs which have seen a large demand for care via telemedicine. In the third quarter, 2016-17 community investment base funding was allocated towards 2.0 additional FTE Registered Nursing resources to add to the existing 10 FTEs received from the Ministry as part

of the 9,000 Nurses Initiative. The additional resources were provided to fill the gap in programs which were operating with only partial FTEs and challenged to meet patient needs as a result.

Assertive Community Treatment Team (ACTT)

The NSM LHIN provided \$416,466 in new base funding annually to support the Assertive Community Treatment Team (ACTT) to provide services to the South Georgian Bay sub-region. The program was developed in partnership between Canadian Mental Health Association Simcoe and Collingwood General and Marine Hospital Community Mental Health, as well as in partnership with NSM LHIN Mental Health and Addictions Care Connections Coordinating Council.

An Assertive Community Treatment Team is a client centred, evidenced based, best practice service for individuals with severe and persistent mental illness. Individuals receiving ACTT services experience functional impairment, a decreased ability to perform activities of daily living, and have a history of high-service needs. These needs include repeat and/or lengthy hospitalizations, co-occurring substance use, and involvement with the criminal justice system. Assertive Community Treatment services have shown to decrease hospitalizations, dramatically reduce emergency room visits, decrease the burden on family physicians, and support families by allowing for more opportunities to focus on recovery and lifestyle change.

Building off of the Barrie ACTT, which has been operational for nearly a decade, the South Georgian Bay ACTT offers services through a multidisciplinary team approach consisting of: social workers, nurses, addictions workers, a psychiatrist, and peer support workers. The team provides medication and symptoms management, crisis intervention, and support with housing, employment, life skills, and daily living. ACTT services are provided in a client's own choice environment and are provided 7 days a week, 365 days a year, with 24/7 crisis support.

Skills for Safer Living

In 2016-17, \$9,990 in new base funding was provided annually to support the Skills for Safer Living program. The program is currently up and running at CMHA Simcoe, offered in Barrie sub-region and is implemented in collaboration with Georgian College, Suicide Awareness Council of Simcoe and CMHA Simcoe Branch.

Skills for Safer Living is an evidenced based best practice group approach for individuals who have had a suicide attempt. Developed and offered at St. Michael's hospital for over 10 years, this practice has been developed and implemented nationally and internationally. The program provides participants with:

- Assessments
- An education/information session with family/natural supports
- Clinical facilitation
- Secondary facilitation
- Peer facilitation

This program addresses a service gap in Barrie sub-region as there are no targeted services available in the NSM LHIN focused on proactive tools to support individuals with active suicide attempts. The program aims to provide skills development and capacity building for clients who have high risk behaviour related to suicide (i.e. 2 or more suicide attempts). The program decreases system level burden by diverting individuals from hospital and other community

supports and also decreases caregiver burnout. This investment is anticipated to decrease system demand on hospitals and community agencies by supporting clients proactively, but will also directly improve the quality of life for those individuals in the program and their families.

Medical Assistance in Dying

The NSM LHIN established a Medical Assistance in Dying (MAID) committee to meet and collaboratively ensure that there was a mechanism to disseminate legislative, regulatory and clinical information and to provide education when requested to health service providers and the general public. The committee includes representation from acute care, long-term care, home care, primary care, pharmacy, hospice and palliative care. The NSM LHIN developed and implemented a framework to ensure that patients and providers had local support. This was built within the existing palliative care network to ensure that all MAID requests had an opportunity, where clinically appropriate, for optimizing palliative care supports. Leveraging formal and informal clinical networks, we were able to ensure that barriers to MAID provision were identified and managed. Approximately 50% of the MAID cases reported within NSM have been coordinated through this local system. The committee continues to meet to understand how to continue to improve upon our framework and to determine how this framework aligns with evolving regional systems of palliative care and home care.



Goal 2. Build Capacity and Enhance Coordination

Transitional Bed Pilot Program

In 2015-16, the NSM LHIN funded a three-year regional Transitional Bed Pilot Program, which is currently offered through one of the region's CSS providers. The program supports seniors and adults requiring community-based assisted living and additional services such as personal support and care coordination. Through the program, individuals have access to transitional bed support 24 hours per day, for up to six months. Clients also had access to both CCAC nursing and therapy support and the potential for symptom management for palliative care. The waitlist ranking criteria for the program prioritizes patients who are in hospital with an ALC designation, therefore supporting system flow. Since opening in January 2016, the six-bed program has had an average occupancy rate of 92% and an average length of stay of 36 days. As a regional program, the transitional beds have had referrals from each of the five acute care facilities in NSM. Findings from the LHIN's ALC review indicate that the program has already had an impact on ALC days. In the fourth quarter of 2016-17, the program was provided funding for an additional three beds to bring this three-year pilot program to a total of nine beds. An evaluation framework is currently being finalized and will be used to assess the impact of the program going forward.

Child and Youth Mental Health Program

In November 2016, the Ministry of Health and Long-Term Care announced that it would invest \$3.2 million in annual operating funds for a regional Child and Youth Mental Health program in NSM. The investment will enable Royal Victoria Regional Health Centre to establish a comprehensive regional program, including an eight-bed inpatient unit and a day hospital program that will have capacity for approximately 3,000 outpatient visits annually. This program addresses a significant gap in that NSM was the only LHIN in the province without dedicated inpatient beds for children and youth with acute mental health issues. Services provided through the new program will include prevention and health promotion, assessment, and specialized treatment based on individual needs ranging from moderate to severe and complex conditions.

The program will increase services available in the region, help to reduce wait times for children and youth suffering from mental health challenges and ensure that high quality mental health treatment can be accessed in one location.

eReferral to CCAC

During 2016-17, the NSM LHIN worked closely with its five acute care hospitals, the NSM CCAC and the Ontario Association of Community Care Access Centres (OACCAC) to build an electronic solution for referral from hospital to CCAC home care services and from hospital to long term care placement. In collaboration with the vendors of the hospitals' Health Information Systems, Cerner and Meditech, four electronic interfaces have been built to automate the referral process. In the past, paper referrals were often sent incomplete, which resulted in either rework to complete the information or inadequate information for placement, allocation of services, or clinical decision making. The new system, implemented at the end of 2016-17, will improve patient quality of care and clinical outcomes as well as ensuring efficient access to patient data through the use of mandatory fields. Through the electronic system, no incomplete referral will be sent and the risk of a misplaced referral is avoided. Based on the referrals sent in 2014-15, it is estimated that 12,000 referrals which have previously been paper-based will be sent and managed through the new eReferral process. Work will continue in 2017-18 to ensure hospital referrals to Home and Community Care and LTC are embedded into clinical practice and adoption of the new system is effective.

Regional Palliative Care Network

The Provincial Ontario Palliative Care Network (OPCN) was established in 2016-17. The OPCN serves as the principal advisor to the MOHLTC for hospice palliative care and supports the work of the regional palliative care networks in the development of a coordinated, high quality, patient-centred hospice palliative care system. Aligned with the expectations of the OPCN, each region is required to establish a Regional Palliative Care Network (RPCN) that will serve to plan and develop regional hospice palliative care systems. The 2016-17 deliverables for each RPCN were to establish a governance structure for the RPCN, recruit a network lead and two clinical co-leads, and submit a regional report by March 31, 2017. In Q2, 2016-17, the NSM LHIN and Cancer Care Ontario (CCO), jointly accountable for the NSM RPCN, conducted six community engagement sessions to inform the current state of hospice palliative care in NSM and opportunities moving forward. A network lead and Physician Clinical Co-Lead were recruited. The NSM RPCN Steering Committee (governance structure) was established based on an experience-based matrix and held its first meeting in December, 2016. A work plan was developed and is being finalized to support the expectations of the OPCN for each regional network.

Voluntary Integration

In 2012, Chigamik Community Health Centre (CHC) agreed to provide Midwives Nottawasaga with office space to support the midwives in offering care closer to patients living in North Simcoe. Since 2012, Midwives Nottawasaga had seen a significant increase in client demand from this region. This resulted in the establishment of a Midland specific team of three midwives who continue to informally use office space offered by Chigamik CHC. The midwives have hospital privileges at the Georgian Bay General Hospital (GBGH), as well as Orillia Soldiers' Memorial, and the Collingwood General and Marine Hospital. As such, the midwives are on-call for their clients at GBGH while also providing clinic specific services out of Chigamik CHC. Linked to the mission, vision and values of Chigamik, the midwifery services support a larger continuum of care focusing on a holistic approach to the well-being of clients. This approach is achieved through the integration and co-location of the midwives with primary care providers,

allied support services such as social workers and dietitians, as well as traditional healing services.

In an effort to formalize this relationship, in January of 2017 Chigamik CHC and Midwives Nottawasaga developed a memorandum of understanding (MOU) that clearly identifies the specific roles and responsibilities of each organization and the ways in which their shared services will be managed. Following this, on February 9, 2017, Chigamik CHC and Midwives Nottawasaga submitted a Notice of Intention to Voluntarily Integrate to the NSM LHIN. The goals of this integration are:

- To establish a formal operational framework outlining how each organization will work together while maintaining independent organizational identities.
- To increase awareness and support within the community for local midwifery services.
- To reduce costs and barriers for clients within the community to receive midwifery care.
- To establish a stronger foundation for local midwifery services within North Simcoe.

On March 27, 2017 the Board passed a motion supporting the voluntary integration between Chigamik CHC and Midwives Nottawasaga, as per Section 27 LHSIA (2006).



Goal 3. Drive System Sustainability

Muskoka and Area Health System Transformation Council

In June 2016, the NSM LHIN Board of Directors approved the formation of the Muskoka and Area Health System Transformation (MAHST) Council as the next step in developing an integrated health care model for Muskoka and the surrounding area. The LHIN appointed a local Chair for the Council and secured Dr. Adalsteinn Brown to serve as Co-Chair and Special Advisor to the Council. Executive and General Councils were formed for MAHST and these were supported by five working groups dedicated to programs and services, funding and governance, information management and technology, way finding, and stakeholder relations. The Council established its project scope for the near and longer term and will report back to the LHIN in 2017-18 with a recommended framework for the design of a transformed local health system. The comprehensive model will be evidence-based, aligned with the LHIN's strategic plan, and will serve the best interests of the people of Muskoka and area. The framework will then be implemented in phases as part of a ten-year plan for the Muskoka sub-region.

Health Based Allocation Model Working Group

As one component of Health System Funding Reform (HSFR), a portion of hospital funding is allocated using the Health Based Allocation Model (HBAM), which is an evidence-based formula that uses demographic and clinical data to inform funding. In 2016-17, the Ministry provided funding of \$139 million for hospitals under HBAM to support the delivery of patient care. The HBAM formulary is complex, with one of the required inputs being an annual data submission from each hospital provider. A local working group was established in 2016 to review the financial data submissions of NSM hospitals to improve the quality of financial reporting, share learnings among providers and to identify opportunities for increased funding.

Recommendations to improve alignment of financial costs and patient activity with the HBAM formula were identified and are expected to increase the NSM LHIN share of provincial HBAM funding in 2018-19 and future years. The recommendations were endorsed by the HSFR Local Partnership committee and implementation was completed by the end of fiscal year 2016-17.

Quality Based Procedures Optimization

Under Health System Funding Reform (HSFR), the Ministry provides limited funding of \$46 million for NSM hospitals to provide Quality Based Procedures (QBP), such as hip and knee replacements, cataract surgery, and stroke care. Recommendations to improve utilization of QBP were identified by hospital partners and later endorsed by the HSFR Local Partnership committee. The recommendations supported a reallocation approach for one-time and permanent QBP volumes to optimize services available to patients in the LHIN, in accordance with Ministry volume management principles. The recommendations have been approved by the Ministry and appropriate funding reallocations of \$700,000 within the LHIN have been completed. This work demonstrated strong collaboration and system-level thinking among NSM's individual hospital providers to ensure full utilization of funding within the region.

Critical Care

NSM acute care sites continue to improve transitions in care between Intensive Care Units, focusing on repatriation to the most appropriate hospital, closest to home. The LHIN's goal is to develop a regional critical care program that respects the capacity of each of our hospitals and works collaboratively to support patients accessing the care they need when they need it most. In 2016-17, work began across the region to improve the quality of data being submitted into the provincial Critical Care Information System. More in depth data analysis, with trending has begun to provide a better understanding of variation within our region and how we can address that variation, both at an individual hospital level through quality improvement and at a system level via the regional program.

Emergency Department

It is noted that NSM LHIN has a higher rate of emergency visits for conditions best managed elsewhere than the provincial average. System-wide work on Emergency Department (ED) diversion strategies and public communication are underway, particularly as they pertain to surge planning. The ED and Surge working groups work with primary care to ensure that patients have available options for primary care, throughout the year and particularly in the holiday season. Both the Simcoe Muskoka District Health Unit and the County of Simcoe participate in these discussions. Learning from past experiences, the LHIN initiated the development of a regional surge plan in 2016-17 and it is expected to be completed in the 2017-18 fiscal year. Each hospital in NSM has participated in the emergency return visit program with Health Quality Ontario.

Health Links Community of Practice

NSM has a Community Health Link in each of its five sub-region geographies. Four of the NSM Health Links are led by primary care (Family Health Teams) and in Muskoka, it is being led by the District Municipality of Muskoka - the only Health Link in the province with this structure.

The focus of the Health Links Community of Practice is Health Link sustainability and standardization of practice and care. Areas of focus include reduction in the number of patients waiting for an alternate level of care (ALC), palliative care planning, data quality and consistency, and sub-regional Quality Improvement Plans focused on activities to reduce 30 day readmissions. The group consists of Health Link leaders, care coordinators, and front line staff as required to inform specific initiatives or act as subject matter experts in project work. The Health Links Community of Practice is very focused on the outcomes of community and patient

engagement in each Health Link, and utilizes patient satisfaction survey results and patient stories in every community of practice meeting to drive the work at a regional level.

In 2016-17, the NSM LHIN Health Links reached their target of connecting unattached Health Links patients with a primary care provider at discharge. The Health Links continue to increase the number of complex patients who receive coordinated care. In 2016-17, 869 patients across NSM had Coordinated Care Plans from their respective Health Link. Four out of five Health Links have collaborative quality improvement plans and continue to focus on strategies to reduce 30-day hospital readmissions.

Capital Planning

In 2016-17, the NSM LHIN had no new projects submitted for review. Projects currently under review range from major capital redevelopment to renovation projects. Below is an update on some the projects currently underway:

- Royal Victoria Regional Health Centre (RVH) continues to move the Advanced Cardiac Care Stand-Alone Primary Percutaneous Coronary Intervention Unit project forward. The Ministry approved Stage 4.1 on November 25, 2016. The project construction is expected to be completed in October 2017. The program will provide access to cardiac care closer to home.
- RVH is also undertaking the development of a Child and Youth Mental Health unit which will provide specialized child and youth in-patient mental health needs and supporting ambulatory care services for NSM residents. Operating dollars were approved in 2016 and the project is projected to be completed in November 2017.
- Muskoka Algonquin Healthcare (MAHC) has developed a master plan, and conducted public consultations as to siting of future hospital site(s), programs and services. This planning work continues and the Ministry has supported the development of the plan.
- Collingwood General and Marine Hospital (CGMH) is continuing to plan the redevelopment of the hospital describing the present and future roles and scope of services of the hospital. The hospital completed the renovation of its Emergency Department using its own funds in the first quarter of 2016-17.
- Orillia Soldiers' Memorial Hospital (OSMH) completed renovations to the Neonatal Intensive care unit. The design improvements will enhance the patient experience through efficiency, model of care and safety. A grand opening was held and representatives from the Ministry participated in a site tour to see the final project.
- The Waypoint/Chigamik Joint Project which will house Mental Health Outpatients, Day Hospital, The HERO (Housing, Employment, Rehabilitation Services, Our Place Social Club) Centre and Chigamik's Primary Care and community programs and services pre-capital project was approved. Stage 1 and 2 have been submitted for review.

Engaging our Communities

Governance Quality and Patient Safety

The NSM LHIN partnered with the Canadian Patient Safety Institute and the Canadian Health Services Research Foundation through the Governance Centre of Excellence to offer this session to all health care, community partners and stakeholders across the region.

The purpose was twofold:

- To establish a framework for quality and patient safety in NSM, and to provide access to a toolkit that governors could access following the training,

- To provide a forum for networking among Board members and to facilitate interaction and future collaboration.

Participants came away with a clear understanding of the role governors play in ensuring client safety and satisfaction at their own organizations, as well as at a health system level. They had many new colleagues to continue to connect with. Tools and techniques that were taught were provided in hardcopy with access to online learning and information centres.

NSM Palliative Care Sessions

The Ontario Palliative Care Network (OPCN), Cancer Care Ontario (CCO) and NSM LHIN partnered to provide an overview of the work they are doing together with regards to palliative care in our region, and to consult on opportunities to provide input/feedback on improving local services.

Sessions were held in each of the five sub-regions of NSM as well as a session for stakeholders from First Nation, Métis, and Inuit (FNMI) communities. Common themes identified included: the importance of unique individuals such as navigators, chaplains, local municipal leaders, 211 staff and spiritual leaders, the importance and benefits of collaboration and partnership, the need for access to education, opportunities for early identification, opportunities to increase capacity, the need to improve transitions and coordination of care, and the need for more public education.

Participants at the FNMI discussion reflected on the significance and need for greater understanding, respect, and inclusion of cultural-based care within the delivery of hospice palliative care to urban and rural aboriginal people. It was stated that palliative care is intrinsic within aboriginal culture, supporting community members throughout their journey including end-of-life care. One group reinforced this understanding describing their ideal vision for palliative care as “Nigeewaymin,” going home. Participants spoke of the need for greater awareness by mainstream providers for traditional and spiritual practices and practitioners and to include these providers within care delivery, leveraging and engaging what is already available within the community. While they noted improvements from local health providers in working with aboriginal communities and collaborating with traditional practice and culture, they reflected the need for strengthened cultural sensitivity, awareness, and support by direct care providers and the system as a whole. They also spoke to the need to better support family and caregivers with bereavement and respite.

NSM Acute Care Governance Sessions

The purpose of this group meeting is to broaden the understanding of issues and success at each of the acute care hospitals, and to discuss opportunities for system and cross-sector work. It is recognized by this group that with the largest amount of spending in NSM being directed to acute care hospitals, there is an obligation to work together to ensure that the system is operating as effectively and efficiently as possible.

Long-Term Care (LTC) Sector Summit

At the LTC sector's request, the NSM LHIN established meetings with representatives from long-term care. On October 13, 2016, more than 30 Administrators, Executive Directors, Directors of Care and other interested staff gathered to share and discuss:

- The latest on Quality Improvement.
- An alternative method for gathering and analyzing data – Point and Click Analytics.
- A new transportation portal and the opportunity to pilot a project within NSM.

- An overview of what an age-friendly community could/should look like.
- A summary of revisions done to the Repatriation Agreement.
- An overview of the Specialized Geriatric Services initiative work happening within the region.

Diabetes Event

On November 23, 2016, the NSM LHIN organized a half-day forum to gather front line caregivers and local experts working in diabetes care for an information sharing/networking opportunity. Led by Dr. John McFadyen, community and care providers came together to share innovative work happening locally, best practices and to dialogue with the goal of improving the care journey for their clients. Prior to the event, the NSM LHIN partnered with community members and produced a video documenting local residents' experience with diabetes. The video was shown to the providers at the event and continues to be shared with health service providers.

Visioning Day

In December 2016, a large number of community, health care, resident, client and caregivers were gathered to discuss what system transformation could look like in NSM. Several themes emerged:

1. **Silos, unnecessary duplication, and access challenges remain:** Further collaboration and integration is needed to create continuity of care across providers, and to enable the efficient and effective use of our resources. Access to care is not necessarily simple. Discussion included what we can do to better coordinate, navigate, streamline, and standardize care, and how we can best share and target the resources we have while building in flexibility for local variances and/or changing need.
2. **Informal caregivers aren't always recognized and enabled:** Informal caregivers provide important care that complements the work that we do. Participants deliberated on ways we can plan better with these health resources in mind, and enable them to continue the care they provide. Services should be co-designed with users and those who support them.
3. **Common technologies and data could be improved:** Current data systems collect useful data; however, the data could be targeted and analyzed to measure system outcomes and allow for timely decision-making.
4. **Communication is limited:** Communication needs to be strengthened across providers, patients, and families to enable planning and continuity of care.
5. **Social determinants of health need recognition:** There is a need to collaborate beyond traditional health planning tables and include partners that impact the social determinants of health such as other Ministries and municipalities.
6. **Leading practices and local working models should be applied:** There is lots that is working well in NSM. We need to identify, conserve and connect the dots on what's working and learn from others.

Following the Visioning Day, participants were invited to join smaller focus group meetings to validate information gathered from the larger group and comment on their preferred method of communication.

Information gathered from the Visioning Day and focus group meeting will be provided to the new LHIN board in 2017-18. The information will help facilitate a refreshed vision, mission and values.

Annual NSM LHIN Care Connections Forum & Aboriginal Health Care Forum

The NSM LHIN held two forums this year. In May 2016, the LHIN forum focused on the Patients First Action Plan and provided the opportunity to discuss provincial and local health system transformation. In March 2017, the LHIN and Aboriginal Health Circle jointly hosted a forum providing an opportunity to come together for real change and to mirror the provincial direction of the inclusion of Indigenous health as a key driver in designing a system to meet our collective needs.

May 11, 2016 Forum

This event offered an opportunity for NSM health service providers to hear from health care leaders and front-line care givers about new directions, leading practices, and innovations that may assist in delivering the best care for our patients, their families and/or caregivers. We began the day with a patient story to ensure that we move forward with our work truly aligned with the Patients First Act. The patient at the focus of the story, Dan, is a local resident who benefited from a network of health care providers to go from homeless to housed, with ongoing care and treatment at a facility that suits his unique wants and needs.

We developed an agenda that engaged, educated and resulted in stakeholders being able to move forward with the proposed changes coming to our health care system. Keynote speaker, Gail Donner, reflected on the *Bringing Care Home* report which reflected client and caregiver voices. This was followed by a facilitated panel discussion on system changes that truly put patients first.

The afternoon consisted of four break-out sessions: health system funding and sustainability, the evolution of Community Health Links, patient safety and quality from a governance perspective, and enhancing the patient, family, caregiver experience – which was co-facilitated by Aman Sium of Health Quality Ontario and Russ Whyte, a member of the NSM LHIN Patient, Caregiver, Family Advisory Panel.

March 28 and 29, 2017 Forum

Experts from the South Central Foundation in Alaska and the Ontario College of Family Physicians came to share their knowledge and experience with regards to the Nuka and Patients' Medical Home models of care with the goal of stimulating idea creation, sharing of best practices and fostering new partnerships and relationships across our region.

More than 400 local, provincial, and ministerial stakeholders came together for two days to discuss local health care and brainstorm about how our local care system could develop to look like the Nuka and Patients' Medical Home models of care.

NSM LHIN Patient, Caregiver, Family (PCF) Advisory Panel

Following an intensive first year of education and discussion about our local health system, PCF Advisory Panel members contributed to several initiatives throughout 2016-17. These included:

NSM LHIN Care Connections Forum Planning

Health Quality Ontario worked with one of the NSM LHIN PCF Advisory Panel members to co-create and facilitate a Patient, Caregiver, Family breakout session at the forum. Some of the topics addressed through this session included engaging patients and caregivers across the system, choosing meaningful projects, participating successfully in committees, and engaging with advisors. This also prompted a second meeting in August between HQO and the Advisory Panel to work on refining tools and techniques for effectively engaging clients, caregivers and

family members in work, creating patient advisory panels, evaluating that work, etc. This was to be posted on the HQO website for provincial use.

Specialized Geriatric Services (SGS) – Clinical Design Consultation for Input

Work that the SGS Planning Group has begun was presented with an invitation for input. The Advisory Panel members provided key feedback for the group to use in their work going forward:

- Information needs to be easily accessed and clear.
- It would be easiest if there was one point of contact/intake, etc. for clients (ease of navigation).
- Education is a key component to success – familiarizing both clients and their informal caregivers with information as well as health care professionals so they can help their clients navigate the system more easily. Open discussion about available services to remove stigmas was also considered important.
- Caregivers and family members, as well as the client themselves, need to be included in ‘care teams’ as they are the best source of information (historically and currently).

The SGS team plans to continue to bring their ongoing work to the NSM PCF Advisory Panel to ensure that the client and caregiver perspective is there and there are no gaps moving forward.

‘One Sector’ Personal Support Services (PSS) Implementation Initiative

The NSM PSS ‘One Sector’ vision document was brought to the Advisory Panel to ensure that it resonated with client and caregiver perspectives. The group was provided an overview of home and community care in Ontario and PSS Regulatory Amendment and Policy Implementation. The work to date of the NSM PSS Implementation Working Group was explained and discussed. Members feel that programs like this and SGS should align better with regards to a client ‘classification’ system (e.g. low, moderate, high needs vs. SGS’s frailty scoring). Concerns were flagged with discharge planning, and hospital wait times for complex patients. Comments from this session were taken back to the NSM PSS Working Group to continue to engage with the NSM Patient Family Caregiver Advisory Panel on a regular basis as its work continues.

Indigenous Engagement

Given the significant Aboriginal population in the NSM region, the LHIN has continued to actively engage with the Indigenous communities and Indigenous health service providers to ensure the traditions and unique cultural needs of this population are addressed in system planning. Those who identify as Indigenous call attention to challenges they face in receiving equitable access to health services including complexity of federal and provincial funding, lack of sensitivity to their culture, and a deficiency of targeted programs that focus on their particular health needs. Engagement of the Indigenous community helps to ensure that the LHIN continues to be informed by their needs and perspectives, and traditional practices and the unique cultural needs of this population are honoured and incorporated. The NSM LHIN makes concerted efforts to have individuals who identify as Indigenous participate on all LHIN planning and engagement groups. Over the course of 2016-17, the number of groups with Indigenous representatives has increased.

Aboriginal Health Circle Meetings

These meetings are led by Indigenous service providers in the community. They are attended by the LHIN, and are a valuable opportunity for the LHIN to learn more about the needs of the community, and communicate opportunities for indigenous participation in regional initiatives.

Aboriginal Health Forum

The two-day Aboriginal Health Forum, held each spring, explores health issues across the life cycle, through a format of interactive workshops, key-note speakers, and community discussion. Participants gain a better understanding of the holistic perspective of health, wellness, and Mino'Bimaadziwin (meaning "The Good Life"). The forum is attended by health care partners, the LHIN, and members of the community. It has strong attendance and increases the visibility of the indigenous community in health care. This year, the LHIN partnered with the Aboriginal Health Circle to bring experts from the South Central Foundation in Alaska to discuss the Nuka System of Care.

Meetings with First Nation Band Councils

The Aboriginal Health Circle, NSM LHIN leadership and Indigenous Health Lead have annual meetings with the leaders of the four First Nations communities in NSM: Beausoleil, Chippewas of Rama, Wahta Mohawk, and Moose Deer Point.

The purpose of these engagements is to improve health equity and outcomes for the First Nation, Métis, and Inuit (FNMI) populations. Relationships are continually being built and strengthened to ensure that the FNMI community is engaged in health system improvement. Emerging issues can be identified, and feedback can assist with removing barriers in support of equitable access to care. These sessions also facilitate improved understanding of existing regional, provincial, and federal health planning and service delivery within the FNMI community. The continued involvement and engagement of the NSM LHIN's indigenous residents in system planning is crucial.

In 2016-17, the engagements with local communities, identified the need for improved system navigation. The LHIN allocated base funding to the Beausoleil First Nation to fund a navigator to support, advocate, facilitate and coordinate access for Indigenous patients and their families. Also based on community input, the LHIN provided base funding to the Moose Deer Point First Nation to support a transportation program and expand its existing meals on wheels and adult day programs.

Francophone Engagement

In North Simcoe Muskoka, eight identified providers and one designated provider offer health care services in French across our region. A continued partnership with the French Language Health Planning Entity (Entité 4) is key in advancing the LHIN's priority of meeting the needs of the Francophone community. The primary role of Entité 4 is to support the engagement of the Francophone population by soliciting feedback regarding health needs and priorities, health services available, and the potential identification of organizations for French Language Services (FLS). Feedback from the community can then be used as the foundation for informed, evidence-based, and patient-centred planning.

NSM French Language Services Community of Practice (FLS COP)

The FLS COP consists of all NSM French language identified and designated health service providers in the region. Organizations that are not LHIN-funded are also represented. This Community of Practice collaborates to share best practices, policies, resources, and lessons learned. In doing so, they enable the work of building and supporting French language services across the region. At the same time, the LHIN leverages the expertise of the group to overcome barriers and gaps which have been identified in an effort to assist in improving LHIN-wide service provision.

Community Partners with Schools (COMPASS) Meetings

These monthly meetings are attended by elementary and secondary school representatives and community mental health service providers. The goal is to enhance healthy child and youth development, and to reduce social, emotional, or behavioural barriers to learning. The LHIN French Language Services Coordinator is also linked to these groups to improve relationships between Francophone community organizations, school boards, and the LHIN. These partnerships support the development of French language services for Francophone youth with regards to mental health and addiction.

Health Service Providers FLS Committees

These meetings are attended by key stakeholders within the organization and include members of the community, Entité 4, and the French Language Services Coordinator. Implementation and delivery of French language services should be integrated into the day-to-day operations and culture of health service providers. By-laws, policies and procedures, communication strategies, planning processes, should be reviewed for their fit with French language services. This committee supports the implementation of these actions and deliverables in order to improve knowledge of requirements regarding French language services and of the needs and concerns of Francophone patients/clients.

Local Community Engagements

The NSM LHIN continues to work closely with Entité 4 to maintain and enhance existing collaborative working relationships, and to continue to engage the Francophone community. Entité 4 plays a key role in addressing the needs of the Francophone community in the region. By partnering with and advising the LHIN on how best to overcome existing barriers, and improve access to and accessibility of French language services, Entité 4 continues to support the delivery of excellent care.

Improved access to French language services requires concerted efforts by all major stakeholder groups, including LHINs, health service providers, health care professionals, political decision-makers, training institutions and communities. Entité 4 works collaboratively with the LHIN to ensure a Francophone perspective is included in the planning and integration

of health services in the region. A joint action plan between the NSM, Central, and Central East LHINs and Entité 4 has been developed to improve access to the right French language care, at the right place and at the right time within the following priority sectors: care for seniors, mental health and addiction services, primary care, and patients with chronic conditions. Entité 4 is represented at NSM LHIN planning tables aligned with the priority sectors identified above and at NSM's Leadership Council, which helps in ensuring that issues relevant to our Francophone population are reflected in the LHIN's planning.

The NSM LHIN continues to provide French language services in compliance with the French Language Services Act, including local FLS obligations in service accountability agreements of identified and designated providers. The LHIN requires that all health service providers (including contracted service providers) submit an annual FLS report, which is based on the criteria developed by the Office of Francophone Affairs. The LHIN uses this information to assess health service provider capacity to offer and plan for the provision of services based on community need.

The NSM LHIN and Entité 4 have maintained a strong working relationship and have pursued a number of collaborative initiatives aligned with the joint action plan. In 2015-16 and 2016-17, the LHIN and the Entité partnered with NSM's Mental Health and Addictions Coordinating Council to provide the Mental Health Commission of Canada's Mental Health First Aid program in French to health service providers and the general public. The aim of the program is to improve mental health literacy and provide the requisite skills and knowledge to help participants better manage potential or developing mental health problems in themselves or others. The LHIN and the Entité also partnered to establish a French Language Services Patient Navigator position at Centre de Santé Communautaire Chigamik CHC in November 2016 based on an earlier pilot program. The FLS Patient Navigator provides health system navigation and case management support to Francophone clients within the region. The continued partnership between the LHIN and Entité 4 demonstrates a joint commitment to improving access to French language health services for the local Francophone and French-speaking populations.

Ministry-LHIN Accountability Agreement

Performance Indicators

Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services

Significant effort has been directed towards improving performance on this indicator, with corresponding positive results. The Q3 2016-17 value for this indicator was within 10% of the provincial target and was better than provincial performance. North Simcoe Muskoka is sustaining a positive upward trend; this is in contrast to provincial performance, which has been relatively stable. On a year over year basis, NSM LHIN has been consistently improving and is on track to attain the provincial target in the next two years. When the patient availability is considered within the measurement methodology (planned for Q1 2017-18), the likelihood of achieving the target of 95% is high.

Business process improvements both internally and with our service providers, as well as changes to wait list management over the past year, have been responsible for moving this

indicator in a positive direction. Specifically, elimination of the personal support waitlist in Q3 through Q4 has contributed to improved access for patients.

Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services

NSM LHIN performance for this indicator has been very stable over the past two years with only a 1.5 percentage point variation between the highest and lowest performance, indicating that this number may have reached a plateau. Analysis of the first date that the patient will be available (especially for patients referred from hospital) demonstrates that patients are often seen in more than five days due to pre-planning and clinical need for a visit on a specific date. When the patient available date is considered within the measurement methodology (planned for Q1 2017-18), the likelihood of achieving the target of 95% is high.

90th Percentile wait-time from Community for CCAC In-Home Services – Application from Community Setting to First CCAC Services

In 2016-17, 90% of Community Care Access Centre (CCAC) clients waited less than 53 days for their first visit from a service provider; an improvement of 11 days compared to the last fiscal year. The annual results continued to exceed the provincial Ministry LHIN Accountability Agreement (MLAA) target of 21 days and the provincial average of 31 days.

At the end of January 2017, Home and Community Care implemented changes to the assessment and personal support authorization process (at both Information and Referral and Community Intake) that ensured more timely assessment and authorization of personal support services. Resulting improvements seen at the end of Q4 were sustained into April 2017. The 90th percentile wait time from application to authorization was 36 days for Q3, with the 90th percentile wait time from authorization to first service being 16 days for personal support and five days for nursing. These two services account for 69% of the cases included in this indicator so continued reduction in the wait times from application to authorization has the potential to continue to move this indicator in a positive direction. The next largest cohort of clients is those receiving occupational therapy, which accounts for 13% of authorized services. The wait time from authorization to first service for occupational therapy was 19 days, similar to the wait time for personal support. The remaining therapy services had longer wait times that exceed the targets for combined times from application to authorization to first service. Addressing the therapy wait times is a priority for NSM over the next fiscal year. Changes in the therapy authorization and waitlist process will need to occur in order to achieve the target of 21 days by March 2018.

Emergency Department Length of Stay (ED LOS) for complex patients and minor/uncomplicated patients

During 2016-17, there were 259,421 emergency department (ED) visits to hospitals in the NSM LHIN, the majority occurring at two high volume community hospitals, Royal Victoria Regional Health Centre and Orillia Soldiers' Memorial Hospital. These two sites saw approximately 52% of the LHIN's total ED volumes for the year.

Over the 2016-17 fiscal year, the 90th percentile ED length of stay for complex patients was nine hours in NSM LHIN Emergency Departments. This is about four minutes longer than the 90th percentile wait time in 2015-16. Despite this increase, NSM LHIN performed more than a full hour better than the provincial 90th percentile wait of 10.38 hours.

The indicator results for complex and admitted patients is driven by the wait times for admission to beds, particularly at OSMH and RVH. Specifically, the NSM LHIN ED length of stay for non-

admitted complex patients meets the target at 6.5 hours and is negatively impacted by the length of stay for admitted patients which was 25.5 hours. It was also noted that the NSM LHIN rate for the monitoring indicator “Hospitalization Rates for Ambulatory Care Sensitive Conditions” is comparably higher than half of the other LHINs and may negatively impact bed availability, as overall NSM LHIN hospitals admit fewer CTAS IV and V (Uncomplicated) than half of the other LHINs.

The overall 90th percentile ED length of stay for all non-admitted patients of higher acuity levels (CTAS I-III) was 7.4 hours as compared to the provincial 90th percentile wait of 8.7 hours. While NSM ED length of stay for these complex patients has been increasing slowly, trending indicates that it is slower than the increasing provincial rate and so it is predicted that rates will remain below the provincial average for the next year.

In looking at uncomplicated patients, the annual ED length of stay decreased from 4.37 hours to 4.25 hours and was six minutes longer than the provincial 90th percentile wait of 4.15 hours. For fiscal 2016-17 NSM hospitals’ ED length of stay for minor/uncomplicated patients was 18 minutes longer than the provincial 90th percentile length of stay. NSM LHIN performance is within 10% of the provincial target.

It is noted that the NSM LHIN has a higher rate of emergency visits for conditions best managed elsewhere than the provincial average. System wide work on ED diversion strategies and public communication are underway, particularly as they pertain to surge planning. In combination with tying ED Pay for Results (P4R) to hospital agreements and beginning to analyze and understand access to primary care, strategies are being developed to sustain continued decreases in ED length of stay for both complicated and uncomplicated patients.

Percent of priority 2, 3 and 4 cases completed within access target for MRI scans

The proportion of MRI cases completed within target times has been increasing slowly from Q4 of 2015-16 to Q4 of 2016-17, having a rate of 55.41% completion within target. Overall NSM LHIN annual performance improved by approximately 6% from 2015-16 and 9% from 2014-15. Furthermore, the 90th percentile wait time for Q4 fell to 59 days at Royal Victoria Regional Health Centre and 90 days at Orillia Soldiers’ Memorial Hospital as compared to the provincial 90th percentile wait time of 102 days.

At RVH, the volume of Priority 2, 3 and 4 scans increased from 13,763 in 2015-16 to 17,540 in 2016-17 which is a 27% increase. The increase in volumes at RVH can be attributed to their decision to allocate a significant portion of their own operating funds on a one-time basis in 2016-17 to the provision of additional MRI volumes. This allocation was used to implement midnight shifts on both scanners.

The NSM LHIN provided one-time funding to OSMH in the form of health service provider reallocations in Q4 of 2016-17 to address MRI wait times. This allowed OSMH to increase the hours of operation of their scanner, which resulted in an increase in the volume of completed scans from 1,449 in Q3 to 2,135 in Q4 or a 47% increase.

Further progress towards meeting the provincial target will be contingent on finding continued funding to sustain the successful changes initiated by both organizations in 2016-17.

CT Scans

Performance improved from 73% of scans completed within target in 2015-16 to 75% in 2016-17. This can be attributed to increases in Q3 and Q4 to 80% and 88% respectively.

The 90th percentile wait in days for CT priority 2, 3 and 4 scans in NSM has dropped consistently over 2016-17 from 67 days in Q1 to 21 in Q4. This has been accomplished with only a 3% increase in the volume of scans completed. Changes in scheduling and coordinated access continue to be considered by NSM providers so that gains made should be sustained over 2017-18.

Priority 2, 3 and 4 Cases Completed within Target – Hip Replacement

While the NSM LHIN continues to perform favourably relative to the province, the LHIN's performance for completing elective hip replacement surgeries within target wait times declined between 2015-16 and 2016-17. While NSM LHIN performance has slipped slightly from the previous fiscal, it is within 1 percentage point of provincial performance.

There are significant variations between providers in NSM with Royal Victoria Regional Health Centre meeting the provincial target, and Collingwood General and Marine Hospital and Orillia Soldiers' Memorial Hospital missing the target. Both organizations do complete all of their allocated Quality Based Procedures. The NSM LHIN provided additional volumes for Q4 of the fiscal year, which resulted in OSMH increasing from 58 hip replacements completed in 2015-16 to 76 completed in 2016-17. CGMH more than doubled its completed hip replacements from 31 in 2015-16 to 75 in 2016-17.

The decrease in the percentage of cases completed within target is consistent with moving long waiting individuals off the wait list and increased volumes and is indicative of demand exceeding supply. So while performance on this indicator declined, it is reflective of more individuals receiving the necessary care.

Priority 2, 3 and 4 Cases Completed within Target – Knee Replacement

NSM LHIN performance on this indicator decreased from fiscal year 2015-16 to fiscal 2016-17 related to fewer cases meeting the targets in the first 2 quarters of 2016-17. For Q4 of 2016-17, NSM LHIN performance was within 10% of the provincial target with a consistent upward trend.

There are significant variations between providers in NSM with Royal Victoria Regional Health Centre meeting the provincial target and Collingwood General and Marine Hospital and Orillia Soldiers' Memorial Hospital missing the target. Both organizations do complete all their allocated Quality Based Procedures. The NSM LHIN provided funding for additional volumes for Q4 of the fiscal year, which resulted in OSMH increasing from a volume of 77 completed knee replacements in 2015-16 to 107 in 2016-17, a 39% increase. CGMH increased from a volume of 52 completed knee replacements in 2015-16 to 132 in 2016-17, which represents a 132% increase.

Again, the decrease in the percentage of cases completed within target is consistent with moving long waiting individuals off the wait list with increased volumes and is indicative of demand exceeding supply. So while performance on this indicator declined, it indicates that more individuals have received the necessary care.

Percentage of Alternate Level of Care (ALC) Days

Patients who no longer require the intensity of services provided in the hospital are designated Alternate Level of Care (ALC). NSM LHIN performance improved over last fiscal with the

proportion of total patient days that were attributed to ALC decreasing from 23% in 2015-16 to 18% in 2016-17.

Percent ALC days has shown a consistent downward trend since Q4 of the previous fiscal year and NSM LHIN performance is approaching that of the province . Current performance for this indicator is the best it has been in the previous two years. Counterintuitively, this indicator often gets worse as the ALC rate improves as it is sensitive to the discharge of long-stay patients. However, this fiscal year, there has been improvement in both the ALC rate and percentage of ALC days indicating that there has been some traction in addressing ALC issues.

Quarter over quarter for 2016-17, both Orillia Soldiers' Memorial Hospital and Collingwood General and Marine Hospital have reduced their ALC days by approximately half while maintaining patient occupancy. At CGMH, both ALC days and ALC rate have decreased, indicating that throughput (patient flow) has improved. At OSMH, the ALC rate has increased slightly while percentage of ALC days has decreased indicating that while this indicator is improving, significant ALC pressures continue at OSMH and sustained gains may be at risk. Georgian Bay General Hospital has seen a similar trend to OSMH but of lesser magnitude. Both Muskoka Algonquin Healthcare and Royal Victoria Regional Health Centre were relatively unchanged for this indicator quarter over quarter for 2016-17.

Significant planning and resources are dedicated to ALC within the NSM LHIN with some improvement and traction being gained this fiscal year through the work of the ALC Steering Committee and various sub-regional initiatives. Sustaining these gains is a priority for the NSM LHIN for the next fiscal year.

ALC Rate

The NSM LHIN has shown consistent improvement in the ALC rate over this fiscal year and for Q4 of 2016-17 was within 10% of the provincial target for the first time in the past two years.

Multi-sector work over the past two years has contributed to a system based approach to addressing patient flow and access to services. Representation from all hospitals and many community providers has been instrumental in moving this indicator in a positive direction.

The worst annual ALC rate for NSM was fiscal year 2012-13 when 18.0% of patient days were attributable to ALC. The annual rate for 2016-17 was 14.3%. When comparing these two fiscal years, progress was made most significantly in reducing the ALC to LTC rate which fell from 11.1% to 3.9%. However, during that time, there was an increase in the ALC to CCAC rate, the ALC to supervised or assisted living and ALC to convalescent care. This may reflect improvements in patient flow and increased utilization of alternative services to support discharge. Careful monitoring of this trend is ongoing to avoid overloading these sectors and to maintain gains on this indicator.

Repeat Unscheduled Emergency Visits for Mental Health Conditions

The NSM LHIN continues to demonstrate good performance in this indicator. Performance improved from 17.18% in 2015-16 to 16.15% in 2016-17 and is better than provincial performance of 20.39%. NSM LHIN performance meets and exceeds the provincial target.

Strong representation by community-based services at the Mental Health and Addictions Planning Table has contributed to systems-based planning and approaches to mental health care. Cooperation and planning by hospital-based and community based providers at a sub-regional level is aimed at addressing patient and system needs unique to each sub-region.

Wait times for all mental health services in NSM, with the exception of Abuse Services are significantly lower than the provincial average for both the median wait and the total range for the wait times indicating that community supports including rapid response and client initiated visits are available in the region.

Repeat Unscheduled Emergency Visits for Substance Abuse Conditions

NSM LHIN performance decreased by 1.5% for this indicator from 2015-16 to 2016-17 but remained within 10% of the provincial target and was 9% better than provincial performance of 31.4%. Quarter over quarter, NSM LHIN performance steadily improved with Q3 performance meeting the provincial target.

Strong representation by community-based services at the Mental Health and Addictions Planning Table has contributed to systems-based planning and approaches to mental health and addictions care. Cooperation and planning by hospital-based and community-based providers at a sub-regional level is aimed at addressing patient and system needs unique to each sub-region.

Work is underway to track and trend substance use issues by sub-region and by substance type to inform future planning. In cooperation with the Simcoe Muskoka District Health Unit, the NSM LHIN is working to develop an intersectoral opioid strategy. Successful implementation of the rental subsidy program may also have had an effect on this indicator as shelter insecurity contributes to hospital utilization.

Wait times for community-based drug and alcohol programs in NSM vary dependent on the program. While some median wait times are longer than the provincial average, particularly the wait times for community withdrawal management, the wait time range is significantly shorter than the provincial range. This indicates that while access may be slightly slower, overall access to programs is more equitable and ultimately more efficient. In particular, the provincial wait for individuals to obtain drug and alcohol support within housing is up to 700 days whereas the wait for individuals in NSM is at most 107 days. Increasing this level of support where the individual lives may contribute to decreased use of the ED and improved shelter security.

Readmission within 30 Days for Selected HBAM Inpatient Grouper (HIG) Conditions

The NSM LHIN annual readmission rate for selected HBAM Inpatient Grouper (HIG) conditions is 15.56%, which represents an improvement of over 1% from 2015-16 performance (16.81%). NSM's performance is also 1% better than that of the province (16.51%) for the same time period. NSM LHIN performance has been consistent over the past two years for this indicator and is within 10% of the provincial target.

This indicator is being monitored by the Regional Quality Advisory Council in its focused work to improve transitions in care. Each existing LHIN Clinical Council is aligning a component of its work to these efforts.

For diagnostic groups where NSM LHIN partners are aware of demographic risks and stresses (e.g. high levels of COPD and associated risk factors), significant coordination between Health Link Partners at the sub-regional level has resulted in a lower than expected readmission ratio. The CHCs, Health Links and other partners have focused efforts and programs on managing COPD and diabetes in North Simcoe sub-region and South Georgian Bay sub-region and have seen positive results in avoiding readmissions. Work at Royal Victoria Regional Health Centre focused on stroke and cardiac has yielded similar results.

Quarter over quarter readmissions for the gastrointestinal cohort have been highest. This is a diverse cohort but upon closer analysis, it is apparent that gastrointestinal obstructions are the most common diagnosis readmitted within the 30 day time frame. Future work will be required to address readmissions for this cohort. Multiple NSM providers have identified CHF community and outpatient based treatment as the next priority cohort to address in their Quality Improvement Plans submitted to Health Quality Ontario.

North Simcoe Muskoka LHIN – Performance Indicators 2016-17

No.	Indicator	Provincial target	Provincial				LHIN			
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	85.36%	82.10%	85.58%	69.53%	77.19%	86.45%	84.26%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	94.00%	93.83%	94.53%	91.52%	93.08%	92.09%	92.65%
3	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	21 days	29.00	29.00	29.00	31.00	69.00	67.00	51.00	53.00
4	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	9.97	11.03	10.38	8.95	9.03	9.30	9.10
5	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.23	4.15	3.95	4.37	4.25	4.25
6	Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	41.75%	38.43%	40.76%	40.17%	20.24%	23.09%	55.41%	29.78%
7	Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	77.77%	74.66%	78.31%	75.89%	73.76%	73.36%	88.09%	75.69%
8	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	77.89%	78.47%	90.62%	81.32%	76.43%	77.26%

No.	Indicator	Provincial target	Provincial				LHIN			
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
Performance Indicators continued										
9	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	74.50%	75.02%	88.66%	84.52%	83.55%	75.69%
10	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.50%	15.85%	15.16%	21.02%	23.83%	16.14%	18.07%
11	ALC rate	12.70%	13.70%	13.98%	15.27%	15.19%	15.04%	15.81%	13.95%	14.47%
12	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.19%	20.39%	19.81%	16.08%	17.18%	16.30%	16.15%
13	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.01%	31.15%	31.40%	25.00%	21.12%	22.39%	23.77%
14	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.66%	16.51%	16.17%	16.81%	15.83%	15.56%
Monitoring Indicators										
15	Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.02%	88.03%	86.82%	87.23%	86.40%	82.21%	82.10%	86.90%
16	Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	96.01%	95.00%	93.00%	93.00%	NA	NA	NA	NA
17	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	88.09%	85.32%	85.01%	94.39%	81.36%	61.37%	68.41%
18 (a)	CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	14.00	14.00	19.50	15.00	16.00	16.00
18 (b)	CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	8.00	8.00	13.00	15.00	29.50	27.00
19	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	4.58	12.28	31.64	28.48	6.95	19.26

No.	Indicator	Provincial target	Provincial				LHIN			
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
Monitoring Indicators continued										
20	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	81.88	241.40	392.71	401.63	97.94	276.97
21	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	46.61%	47.46%	47.81%	40.80%	42.83%	43.60%	43.65%

*FY 2016/17 is based on the available data from the fiscal year (Q1-Q3, 2016/17)

**FY 2016/17 is based on the available data from the fiscal year (Q1-Q2, 2016/17)

North Simcoe Muskoka LHIN Operations

The NSM LHIN managed an allocation of \$6,707,450 in fiscal year 2016-17. The allocation is comprised of the LHIN's base operational budget of \$4,151,655 and special initiative funding of \$2,555,795.

The LHIN received special initiative funding to support provincial priorities as follows:

- Aboriginal Planning
- Critical Care LHIN Lead
- Emergency Department
- Primary Care
- Diabetes Regional Coordination Centre
- e-Health Project Management Office
- Entité #4, planification des services de santé en français
- French Language Health Services
- ER/ALC
- Transition Planning

The Auditor's Report with audited financial statements and accompanying notes follow.

Financial statements of

**North Simcoe Muskoka Local
Health Integration Network**

March 31, 2017

North Simcoe Muskoka Local Health Integration Network

March 31, 2017

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Independent Auditor's Report

To the Members of the Board of Directors of the
North Simcoe Muskoka Local Health Integration Network

We have audited the accompanying financial statements of the North Simcoe Muskoka Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2017, and the statements of operations, change in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of North Simcoe Muskoka LHIN as at March 31, 2017, and the results of its operations, change in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

A handwritten signature in black ink that reads "Deloitte LLP". The signature is written in a cursive, flowing style.

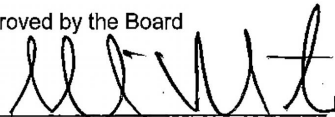
Chartered Professional Accountants
Licensed Public Accountants
May 29, 2017

North Simcoe Muskoka Local Health Integration Network

Statement of financial position
as at March 31, 2017

	2017	2016
	\$	\$
Financial assets		
Cash	583,210	574,738
Due from Ministry of Health and Long-Term Care ("MOHLTC") (Note 9)	151,000	422,741
HST receivable and other	69,165	58,970
	803,375	1,056,449
Liabilities		
Accounts payable and accrued liabilities	587,602	536,780
Due to MOHLTC Ontario (Note 3b)	119,762	169,959
Due to Health Service Providers ("HSP's") (Note 9)	151,000	422,741
Due to Central West LHIN (note 4)	11,830	8,666
Deferred capital contributions (Note 5)	125,705	239,827
	995,899	1,377,973
Net debt	(192,524)	(321,524)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	66,819	81,697
Tangible capital assets (Note 7)	125,705	239,827
	192,524	321,524
Accumulated surplus	-	-

Approved by the Board



Director



Director

The accompanying notes to the financial statements are an integral part of these financial statements.

North Simcoe Muskoka Local Health Integration Network

Statement of operations
year ended March 31, 2017

	Budget (Note 8)	2017 Actual	2016 Actual
	\$	\$	\$
Revenue			
MOHLTC Ontario funding			
HSP transfer payments (Note 9)	872,661,140	892,323,214	872,661,140
Operations of LHIN	4,151,655	4,109,900	4,011,655
Project Initiatives			
Aboriginal Planning	30,000	30,000	30,000
Critical Care Lead	75,000	75,000	75,000
Enabling Technologies for			
Integration Project Management Office	-	411,170	384,803
Emergency Department LHIN Lead	75,000	75,000	75,000
Entite de planification des services de sante en francaise #4 Centre Sud-Ouest	654,064	654,064	654,060
Emergency Room/Alternative Level of Care			
Performance Lead	100,000	100,000	100,000
French Language Health Services	106,000	106,000	106,000
Primary Care LHIN Lead	75,000	75,000	75,000
Patients First Transition Planning and Implementation	-	180,000	-
Diabetes Regional Coordination	837,731	837,731	837,731
Amortization of deferred capital contributions (Note 5)	-	124,071	143,268
	878,765,590	899,101,150	879,153,657
Funding repayable to the MOHLTC			
Ontario (Note 3a)	-	(26,192)	(93,570)
	878,765,590	899,074,958	879,060,087
Expenses			
Transfer payments to HSPs (Note 9)	872,661,140	892,323,214	872,661,140
General operating expenses (Note 10)	4,151,655	4,210,088	4,104,502
Project Initiatives (Note 11)			
Aboriginal Planning	30,000	30,000	30,000
Critical Care Lead	75,000	75,000	75,000
Enabling Technologies for			
Integration Project Management Office	-	411,170	384,803
Emergency Department LHIN Lead	75,000	75,000	75,000
Entite de planification des services de sante en francaise #4 Centre Sud-Ouest	654,064	654,064	654,060
Emergency Room/Alternative Level of Care			
Performance Lead	100,000	100,000	100,000
French Language Health Services	106,000	103,691	102,204
Primary Care LHIN Lead	75,000	75,000	75,000
Patients First Transition Planning and Implementation	-	180,000	-
Diabetes Regional Coordination	837,731	837,731	798,378
	878,765,590	899,074,958	879,060,087
Annual surplus	-	-	-
Accumulated surplus, beginning of year	-	-	-
Accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

North Simcoe Muskoka Local Health Integration Network

Statement of change in net debt
year ended March 31, 2017

	Budget (Note 8)	2017 Actual	2016 Actual
	\$	\$	\$
Annual surplus	-	-	-
Acquisition of tangible capital assets	-	(9,949)	-
Amortization of tangible capital assets	-	124,071	143,268
Change in other non-financial assets	-	14,878	17,919
Increase in net debt	-	129,000	161,187
Net debt, beginning of year	-	(321,524)	(482,711)
Net debt, end of year	-	(192,524)	(321,524)

The accompanying notes to the financial statements are an integral part of these financial statements.

North Simcoe Muskoka Local Health Integration Network

Statement of cash flows
year ended March 31, 2017

	2017	2016
	\$	\$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of tangible capital assets	124,071	143,268
Amortization of deferred capital contributions (Note 5)	(124,071)	(143,268)
	-	-
Changes in non-cash operating items		
Prepaid expenses	14,878	17,919
Due from MOHLTC ("HSP's")	271,741	6,586,333
HST receivable	(10,195)	35,116
Accounts payable and accrued liabilities	50,822	(46,415)
Due to the MOHLTC Ontario	(50,197)	93,570
Due to HSPs	(271,741)	(6,586,333)
Due to Central West LHIN	3,164	8,666
Deferred revenue	-	(6,210)
	8,472	102,646
Capital investment		
Acquisition of tangible capital assets	(9,949)	-
Financing transactions		
Capital contributions received (Note 5)	9,949	-
Net increase in cash	8,472	102,646
Cash, beginning of year	574,738	472,092
Cash, end of year	583,210	574,738

The accompanying notes to the financial statements are an integral part of these financial statements.

North Simcoe Muskoka Local Health Integration Network

Notes to the financial statements

March 31, 2017

1. Description of business

The North Simcoe Muskoka Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the North Simcoe Muskoka Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the municipalities of Muskoka, most of Simcoe County and part of Grey County. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with Ministry-LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC") and provides the framework for the LHIN accountabilities and activities. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSP"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed HSP in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2017.

The LHIN statements do not include any MOHLTC managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, and they are measurable. Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

North Simcoe Muskoka Local Health Integration Network

Notes to the financial statements

March 31, 2017

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and the reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund tangible capital asset purchases, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Leasehold improvements	Life of lease straight-line method
Office furniture and equipment	5 years straight-line method

For assets acquired or bought into use during the year, amortization is provided for a full year.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Segmented disclosures

Management has determined that existing disclosures in the Statement of operations and within the related notes for both the prior and current year sufficiently disclose information of all appropriate segments and, therefore, no additional disclosure is required.

North Simcoe Muskoka Local Health Integration Network

Notes to the financial statements

March 31, 2017

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

- a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

			2017	2016
	Funding received	Eligible expenses	Excess funding	Excess funding
	\$	\$	\$	\$
General LHIN operations	4,109,900	4,086,017	23,883	50,421
LHIN special funded initiatives				
Aboriginal Planning	30,000	30,000	-	-
Diabetes Regional Centre	837,731	837,731	-	39,353
Critical Care Lead	75,000	75,000	-	-
Enabling Technologies	411,170	411,170	-	-
Emergency Department LHIN Lead	75,000	75,000	-	-
Entite de planification des services de sante en francais #4 Centre Sud-Ouest	654,064	654,064	-	-
Emergency Room/Alternative Level of Care Performance Lead	100,000	100,000	-	-
French Language Health Services	106,000	103,691	2,309	3,796
Patients First Transition Planning and Implementation	180,000	180,000	-	-
Primary Care LHIN Lead	75,000	75,000	-	-
Total LHIN special funded initiatives	2,543,965	2,541,656	2,309	43,149
	6,653,865	6,627,673	26,192	93,570

- b) The amount due to the MOHLTC at March 31 is made up as follows:

	2017	2016
	\$	\$
Due to MOHLTC, beginning of year	169,959	76,389
Funding repaid to MOHLTC during the current year	(76,389)	-
Funding repayable to the MOHLTC related to current year activities (Note 3a)	26,192	93,570
Due to MOHLTC, end of year	119,762	169,959

North Simcoe Muskoka Local Health Integration Network

Notes to the financial statements

March 31, 2017

4. Related party transactions

LHIN Shared Service Office, LHINC Collaborative and Health Shared Services Ontario

The LHIN Shared Services Office (the "LSSO") was a division of the Toronto Central LHIN and was subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs was responsible for providing services to all LHINs. The full costs of providing these services was billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN as at February 28, 2017 were recorded as a receivable (payable) from (to) the LSSO. This was done pursuant to the shared service agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC was to support the LHINs in fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system; their role as system manager; where appropriate, the consistent implementation of provincial strategy and initiatives; and the identification and dissemination of best practices. LHINC was a LHIN-led organization and accountable to the LHINs. LHINC was funded by the LHINs with support from the MOHLTC.

Effective February 28, 2017 pursuant to a transfer agreement between Toronto Central LHIN and Health Shared Services Ontario (HSSO) responsibility for the shared services previously provided by the LSSO and the LHINC was transferred to HSSO. HSSO is a provincial agency established January 1, 2017 by O. Reg. 456/16 made under LHSIA with objects to provide shared services to LHINs in areas that include human resources management, logistics, finance and administration and procurement. HSSO as a provincial agency is subject to legislation, policies and directives of the Government of Ontario and the Memorandum of Understanding between HSSO and the Minister of Health and Long Term Care.

Enabling Technologies for Integration Project Management Office

Effective February 1, 2012, the LHIN entered into an agreement with Central, Central West, Central East, Toronto Central, and Mississauga Halton LHNs (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received funding from Central West LHIN of \$423,000 (2016 - \$406,000). The LHIN incurred eligible expenditures related to this funding totalling \$411,170 (2016 - \$384,803). During the year, the LHIN returned \$Nil (2016- \$12,531) to the Central West LHIN. The remaining unspent amount of \$11,830 (2016 - \$8,666) is reported as due to Central West LHIN on the statement of financial position.

5. Deferred capital contributions

	2017	2016
	\$	\$
Balance, beginning of year	239,827	383,095
Capital contributions received during the year	9,949	-
Amortization for the year	(124,071)	(143,268)
Balance end of year	125,705	239,827

North Simcoe Muskoka Local Health Integration Network

Notes to the financial statements

March 31, 2017

6. Commitments

The LHIN has commitments under various operating leases expiring at dates up to 2020 related to building and equipment. Lease renewals are likely. Minimum lease payments due over the remaining terms of these leases are as follows:

	\$
2018	268,547
2019	268,547
2020	111,712

The LHIN also has funding commitments to all HSPs associated with accountability agreements which allocate planning targets for future fiscal years. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Tangible capital assets

			2017	2016
	Cost	Accumulated amortization	Net book value	Net book value
	\$	\$	\$	\$
Office furniture and equipment	893,575	803,646	89,929	168,275
Leasehold improvements	1,180,907	1,145,131	35,776	71,552
	2,074,482	1,948,777	125,705	239,827

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of operations reflect the initial budget at April 1, 2016. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of \$892,323,214 is made up of the following:

	\$
Initial budget	872,661,140
Adjustment due to announcements made during the year	19,662,074
	892,323,214

North Simcoe Muskoka Local Health Integration Network

Notes to the financial statements

March 31, 2017

8. Budget figures (continued)

The total revised operating budget of \$6,707,450 is made up of the following:

	\$
Initial operating budget as reported on the statement of operations	6,104,450
Adjust for funding changes made during the year:	
Enabling Technologies	423,000
Patients First Transition Planning and Implementation	180,000
Revised operating budget	6,707,450

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of \$892,323,214 (2016 - \$872,661,140) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2017 as follows:

	2017	2016
	\$	\$
Operations of hospitals	445,797,205	436,879,064
Grants to compensate for municipal taxation - public hospitals	77,625	77,625
Long term care homes	146,841,685	144,103,019
Community care access centres	105,707,993	101,664,352
Community support services	15,537,085	15,213,671
Assisted living services in supportive housing	8,991,978	8,437,968
Community health centres	11,828,900	11,627,492
Community mental health	27,844,391	27,446,349
Addictions program	5,309,334	5,265,334
Specialty psychiatric hospitals	123,177,528	120,750,514
Grants to compensate for municipal taxation - psychiatric hospitals	23,400	23,400
Acquired brain injury	1,186,090	1,172,352
	892,323,214	872,661,140

The LHIN receives money from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2017, an amount of \$151,000 (2016 - \$ 422,741) was receivable from the MOHLTC and payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and are included in the table above.

North Simcoe Muskoka Local Health Integration Network

Notes to the financial statements

March 31, 2017

10. General operating expenses

The Statement of operations presents General operating expenses by function, the following classifies general operating expenses, by object.

	2017	2016
	\$	\$
Salaries and benefits	2,800,851	2,764,678
Occupancy	224,952	198,089
Amortization	124,071	143,268
Shared services	281,486	318,990
Advertising and public relations	196,788	50,978
Consulting services	171,389	186,102
Other services	105,627	103,203
Supplies, equipment and licences	71,311	78,384
Board Chair Per Diems	60,200	57,525
Other Board Per Diems	58,975	45,350
Board expenses	38,931	32,677
Travel	33,780	33,254
Mail, courier and telecommunications	41,727	92,004
	4,210,088	4,104,502

11. Project Initiatives

The Statement of operations presents total expenses for individual project initiative, the following classifies initiative expenses by object:

	2017	2016
	\$	\$
Salaries and benefits	1,423,129	1,150,772
Occupancy	145,820	106,921
Shared services	101,587	110,174
Advertising and public relations	42,706	10,002
Consulting services	10,602	10,750
Other services	46,150	38,603
Supplies, equipment and licences	8,438	9,445
Medical Professional Services	78,271	174,596
Travel	16,895	18,051
Mail, courier and telecommunications	13,994	11,069
Special project expenditures	654,064	654,060
	2,541,656	2,294,445

North Simcoe Muskoka Local Health Integration Network

Notes to the financial statements

March 31, 2017

11. Project Initiatives (continued)

Expenses incurred in respect of Diabetes Regional Coordination and included above are as follows:

	2017	2016
	\$	\$
Salaries and benefits	611,867	560,535
Operating expenses	225,864	237,843
	837,731	798,378

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 35 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2017 was \$354,986 (2016 - \$315,009) for current service costs and is included as an expense in the Statement of Operations. The last actuarial valuation was completed for the plan as of December 31, 2016. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favor of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

14. Subsequent event

On April 3, 2017 the Minister of Health and Long-Term Care made an order under the provisions of the Local Health System Integration Act, 2006, as amended by the Patients First Act, 2016 to require the transfer of all assets, liabilities, rights and obligations of the North Simcoe Muskoka Community Care Access Centre the ("CCAC"), to the LHIN, including the transfer of all employees of the CCAC.

Effective May 3, 2017 the LHIN assumed the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

The actual financial impact of the transition is not currently known, however it is expected that assets assumed will equal liabilities assumed. Additionally there are no significant commitments being assumed as a result of the transition.

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