North Simcoe Muskoka **LHIN**
RLISS de Simcoe Nord Muskoka

North Simcoe Muskoka Local Health Integration Network

"Working Together to Achieve Better Health, Better Care, Better Value."

Annual Business Plan 2011 - 2012

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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North Simcoe Muskoka LHIN – Annual Business Plan Context

Mandate and Strategic Priorities

The LHIN plans, coordinates and funds health services to meet the specific needs of the people in the community.

In North Simcoe Muskoka, it is recognized that a health system better reflects the needs of the community when it is planned, coordinated and funded in an integrated manner within and by that community.

The North Simcoe Muskoka LHIN's second Integrated Health Service Plan (IHSP) 2010 – 2013 (*Working Together to Achieve Better Health, Better Care, Better Value)* outlines the health system strategic priorities, the goals to achieve an integrated health system and how success will be measured.

North Simcoe Muskoka's Plan continues to support the Ministry's priorities to *improve access to care and to promote equitable access to health and health care for all Ontarians.* It is based on local population health needs, health system trends and stakeholder input that aligns with the three strategic priorities which are:

- **Improving access to appropriate care, beginning with the emergency room and alternate level of care settings in the community or home**
- **Improving chronic disease management beginning with access to integrated diabetes care**
- **Creating an integrated design for the future health system in North Simcoe Muskoka** (defined as the Care Connections Plan – *Partnering for Healthy Communities*).

The NSM LHIN Care Connections ten-year plan is re-examining and realigning the local health system through a fully collaborative process with all local stakeholders – residents, clients, their families and caregivers and many health professionals from across the continuum of care. Care Connections is building the foundation of how the LHIN will work together with health system partners to improve population health (Better Health), the patient experience (Better Care) and sustainability of the health system (Better Value) over the next ten years – *Working Together…North Simcoe Muskoka can achieve Better Health, Better Care, Better Value.*

Overview of NSM LHIN Current and Forthcoming Programs / Activities

The North Simcoe Muskoka LHIN funds 78 health service providers which spans the entire health care continuum in North Simcoe Muskoka. In 2010/2011, we allocated approximately $750 million to the following 93 local health system organizations and/or specific programs:

- 7 Hospitals
- 1 Community Care Access Centre (CCAC)
- 28 Long-Term Care Homes (LTC)
- 3 Community Health Centres (CHC)
- 33 Community Support Service Organizations (CSS)
- 1 Community Support Service – Acquired Brain Injury Organization (CSS ABI)
- 5 Assisted Living Services in Supportive Housing (ALSSH)
- 11 Community Mental Health Agencies
- 4 Community Addictions Agencies

The LHIN does not directly provide health care services. We work with many agencies involved in providing care across the continuum of health including health service providers, social and community care providers, along with municipalities and members of the public. We establish priorities and plans, and fund health services delivered in North Simcoe Muskoka. 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.

As we look to the future, we need to change the way the health system operates today. The status quo can no longer meet the needs of the population. We need to integrate services across and up and down the health system to make it more efficient and effective. Rather than looking at individual services for a specific group of people or sector, we need to look at the health of the population across the entire system of care that surrounds patients, families and caregivers.

We need the courage to make changes within the funding and resources available now.
The public, providers and funders alike clearly want to make the health system here work better, including how we coordinate services, manage information and ensure that patients move from one level of care to another smoothly and in a timely way.

To do so, we need to begin operating as a single system across the continuum of care with the needs of the person as the main focus.

To make system-wide changes successful, we have developed a model to guide how we distribute and integrate services. The Care Connections plan will help us ensure quality health care now that is cost effective and financially sustainable, as well as meeting the future health needs of residents in North Simcoe Muskoka.

Through the Care Connections plan over the next ten years, we aim to improve patient experience, population health and sustainability of the health system. The local health system partners agree that this is attainable, in order to achieve this, we are developing the technology and electronic systems we need for eHealth, and building more accountability at all levels of the health system.

What will Better Health, Better Care and Better Value look like in North Simcoe Muskoka in the next three years?

Better Health

- People will be able to find their way around the health system more easily, no matter where they are in their pathway of care.
- People here will have more options available to get the primary care they need.
- There will be a stronger, more supportive network of community services to serve patients waiting for care.
- People will wait less time in emergency rooms, with fewer people coming into emergency rooms with non-urgent needs as their needs will be met in the community.
- Residents at risk of or living with diabetes will know how, where and from whom to get the care and services they need.
- The community will value education and illness prevention.

Better Care

- Health system partners will pull together, performing as a single, coordinated and integrated system to focus on the needs of the patient.

- Emergency room staff will be able to respond faster to people with emergency and serious health care needs.
- Hospital beds will be more readily available when needed.
- Health professionals will have the skills and tools to share patient diabetes health information electronically.
- People with diabetes will become better self-managers.
- Clients will find it easier to get consistent and high quality care throughout the local health system.
- eHealth / Technology will be widely available and utilized.

Better Value

- Preventing and managing diabetes well will reduce the personal and system costs of this disease.
- Reviewing utilization and demand for service across the region will help us understand where services are duplicated, how to avoid waste and deliver services more efficiently.
- Existing resources will be directed where they are most needed and service delivery will be streamlined to best meet the needs of people.
- Strategic investments will help improve capacity and performance in the ER, and inpatient hospital beds will be used for those patients that require that level of care.

The North Simcoe Muskoka Local Health Integration Network Annual Business Plan for 2011-2012 outlines the LHIN's three strategic priorities for the coming year. It sets out the actions the LHIN is committed to taking in the future and highlights the need to locally develop an integrated design for the future health system in North Simcoe Muskoka.

Environmental Scan

Population of North Simcoe Muskoka

As of 2009, the North Simcoe Muskoka LHIN has a base population of 453,710 which is about 3.5% of Ontario's population. It is also cottage and ski country, a favourite place for recreation year round and retirement. As a result, this region attracts many different seasonal residents, tourists and events. For example, the World G8 Government Summit was held successfully in Muskoka in the summer of 2010. Such factors contribute to large seasonal swings in population and thus in demand for health services. This region is also growing and aging faster than the province as a whole.

- From 2001 to 2007, the population rose 11%. Yet the province's population grew 7.6%. By 2020 the overall population is expected to grow by about 24% in North Simcoe Muskoka.
- Seniors aged 65+ account for 16% of the population. That compares to 13.2% province-wide. In the next 20 years, the 65+ portion of the population in North Simcoe Muskoka is expected to grow almost three times faster than other populations in the rest of the region. That will place more demands on health care services.
- The region's base population is less diverse than other parts of Ontario. It has relatively lower numbers of immigrants and visible minorities. But it has a higher share of Aboriginal Peoples – 3.3% versus 1.4% province-wide. French is the mother tongue for about 3% of this region versus 4.4% province-wide.

Key Drivers of Change in North Simcoe Muskoka

The North Simcoe Muskoka LHIN aims to ensure that:

- quality patient care is delivered to meet local needs
- local health care dollars are spent wisely and appropriately
- care is accessible, well coordinated and sustainable.

Several factors drive the cost of health care up in our community including population growth and aging, chronic disease, mental health challenges and addictions, and higher utilization of services. It is also an ongoing struggle to attract and keep health service providers. As confirmed in 2010/11 with the active engagement and participation of many stakeholders through the Care Connections design phase, all of these have a big impact on planning and making changes or improvements within the region.

With the current provincial economic condition, efficiencies required for the local health system will require some new thinking and the opportunity for conversations to process new means of doing business that enhance sustainability. We need innovative solutions that work within the limitations of today's funding.

Health service providers in the North Simcoe Muskoka LHIN need to rise to that challenge. They need to manage the conditions that drive up health care costs. At the same time, they are accountable for maintaining balanced budgets.

We must all work together to make real changes in the health system in North Simcoe Muskoka, which includes community organizations, health service providers, patients and their families, people who live across the region and beyond, as well as public health, health care professionals and municipalities. The Care Connections plan has truly begun the process of bringing all stakeholders in North Simcoe Muskoka's health system together to find innovative ways to streamline and improve the local system by working more closely together. From January – April 2011, a very comprehensive consultation and design planning phase will be completed and in April we will transition to the implementation phase of the first three years of the ten-year plan.

To achieve this end, communication, collaboration, coaching and empowerment will be required as key factors to achieving success.

Annual Business Plan – Core Content

NSM LHIN Integrated Health Service Plan Priorities (2010 – 2013)

The North Simcoe Muskoka LHIN will continue to focus on three strategic priorities over the next three years. That way, we can make measurable improvements in the patient experience, population health and sustainability of the health system. The Care Connections plan is a comprehensive examination and realignment of all local health resources in consultation with residents and stakeholders in the region. To continue to be able to provide Better Health, Better Care and Better Value, we must work together in new and innovative ways to promote healthy self-management and prevention, and be able to provide comprehensive and easily accessed health care when needed.

The following three Integrated Health Service Plan (IHSP) priorities reflect the vision of a fully integrated health system for North Simcoe by 2020.

Access to Appropriate Care – Emergency Room / Alternate Level of Care Strategy

IHSP Priority:
Improving access to appropriate care, beginning with the Emergency Room and Alternate Level of Care settings in the community or home.
IHSP Priority Description:
Individuals expect the right care to be delivered in the right place at the right time. This includes timely access to care in the Emergency Room (ER), timely access to an appropriate hospital bed, timely access to rehabilitation or other specialized service and timely discharge either back home or to the most appropriate care setting. To better meet the expectations of our community and align with the Provincial Priority, the North Simcoe Muskoka LHIN continues to target strategies to align with our current reality. This reality includes a growing aging population, a diverse geography comprised of many rural communities, seasonal Emergency Room volume fluctuations, and a high prevalence of both chronic disease risk factors and chronic conditions. In 2011/12 we will continue to improve access to appropriate care, with a specific focus on care of patients in the Emergency Room (ER) and care of those designated Alternate Level of Care (ALC). More specifically, the North Simcoe Muskoka LHIN challenges area health service providers to identify and implement initiatives that: • Safely divert appropriate people from the area ERs; • Improve how communication and process occurs when dealing with patient needs to better improve both patient flow and patient transitions; and • Eliminate and/or delay the need to place individuals into long-term care settings to ensure residents live where they chose to live, safely and for as long as possible.

Current Status:

The North Simcoe Muskoka LHIN provides a large number of services designed to improve ER wait-times and reduce the number and percent of ALC patient days. These LHIN funded services are delivered through hospitals, the Community Care Access Centre (CCAC), long-term care homes and community support agencies. Services which impact ER/ALC are provided through base funding as well as Aging at Home funding, Urgent Priorities funding and ER Pay for Results (P4R) funding.

There are currently six ERs in the North Simcoe Muskoka LHIN – Collingwood General & Marine Hospital (CGMH), Georgian Bay General Hospital (GBGH), Muskoka Algonquin Healthcare (MAHC) – Huntsville and Bracebridge sites, Orillia Soldiers' Memorial Hospital (OSMH), and Royal Victoria Hospital (RVH).

ALC days are captured weekly across all North Simcoe Muskoka hospitals, including the Mental Health Centre Penetanguishene. To spur solutions and discussions for change, this information is shared directly with the members of the five LHIN Local Leadership Councils, as well as those stakeholders who can make a difference and have an impact on these numbers.

Trends in ER/ALC:

- In the first three months of 2010, there has been a 4.5% decrease in the number of unscheduled visits to the ER across our LHIN (as compared to the same period in 2009).
- By mid 2010, nine out of ten patients in the emergency room were waiting one hour less than they did within the previous twelve months. At this time, they were waiting 9.2 hours instead of 10.2 hours during this same time period.
- By mid 2010, 56.1% of admitted patients were treated within 8 hours in the emergency room, which is an improvement of 4.6% from the baseline.
- Patients continue to be satisfied with the care they are receiving in the ER. Since the first three months of 2009, the percentage of patients with an overall positive satisfaction rating in the ER has increased from 83% to 86%.
- The number of days for a patient who is designated ALC to their discharge from hospital has continued to decrease from 50 days as measured in the first three months of 2009 to 40 days in the summer of 2010.
- For nine out of ten of these ALC patients, their length of stay was lower than the provincial percentile of 43 days.

Challenges Being Faced:

- ***Rapidly aging population.*** In 2009, North Simcoe Muskoka already had a higher proportion of seniors age 65+ than the provincial average. According to population projections, the population aged 75+ is expected to grow by 92.3% (from 29,850 in 2008 to 57,418 by the year 2025). This rate of growth is much faster than that of the total NSM population over the same time period (38.8%).
- ***Diverse geography and population distribution.*** North Simcoe Muskoka covers a broad geography. The landscape with granite rock ridges and lake-filled region poses challenges of how and when services is provided. The population distribution within North Simcoe Muskoka also impacts the provision of service delivery. For example, seniors, the highest user of health care resources, often reside in rural settings. With growing retirement communities in Collingwood, Wasaga Beach, Midland, Penetanguishene and the Muskoka region, the challenges in delivering health care services across this region will increase.

- ***Chronic disease risk factors and incidence of chronic disease.*** NSM LHIN is working with our Health Service Providers to address the prevention, self-management, readiness for home services and monitoring of chronic diseases. The key to success in managing chronic diseases and providing the care our residents need is accessibility. Vulnerable populations such as seniors need to be able to access health care and professional services close to or in their home. Health care professionals can monitor a larger client base much more efficiently with the use of remote devices, education (of clients, spouses, and care providers) and self-management. The Diabetes Priority and the Care Connections plan implementation will provide a more coordinated approach to integrated care, ensuring clients will have an easier time accessing and navigating health care locally.
- ***Gaps in system infrastructure which limit options available to area residents***. North Simcoe Muskoka has one of the highest rates of unscheduled ER visits in the province. Some of this can be attributed to the needs of the population and the gaps in the system infrastructure. Examples of existing gaps include a limited immediate response infrastructure (i.e. urgent care centers), an insufficient number of primary care providers (i.e. Family Physicians, Nurse Practitioners), poor supportive housing stock, transportation system limitations and gaps in specialized services (i.e. specialized geriatric services, mental health and palliative care). These basic infrastructure gaps require substantial investments which limit funding options and require the LHIN to prioritize between competing priorities. Through the ER/ALC Strategy, Care Connections and innovative programming the LHIN is addressing some of these gaps and ongoing planning and resource investment are required.

Investment into Action:
Looking back over the last year, (2010/11), the North Simcoe Muskoka LHIN continues to see improvements in both ER and ALC performance. These successes can be attributed to aligning funding and action with the ER/ALC Strategy and the commitment of the health service providers to be accountable for the improved targets. As we look forward to 2011/12, we anticipate further success and outcomes as the initiatives outlined next will continue to build momentum in their implementation.

Goal 1: ER Diversion – Funding over the last several years has targeted high-risk ER users to create alternate options for care. Primary care programs like the Intensive Case Management Program with the Algonquin Family Health Team and the Primary Care Geriatric Outreach Program with the Barrie Community Health Center focus on frail seniors. The newly funded LHIN-wide Palliative Care Resource Team supports health service providers and patients in managing palliative care issues. Nurse Led Long-Term Care Outreach teams link Nurse Practitioners with frail seniors in Long-Term Care for the on-site management of issues that historically have resulted in an ER transfer. Re-ACT, a technology that allows remote monitoring of vital signs, supports early identification and management of health status change. The Integrated Regional Falls Program (IRFP) includes services from prevention to specialized geriatric services. The IRFP, which began accepting patients in March 2010, has seen a reduction in falls and fall-related injuries across the region. Options for primary care and new partnerships for programming / service delivery are expanding in North Simcoe Muskoka. Currently there are six Family Health Teams which continue to develop and expand their scope of primary care services. In addition to the Barrie Community Health Center, two new Community Health Centers are in the early stages of operation in North Simcoe – the South Georgian Bay CHC in Collingwood and CHIGAMIK CHC in Midland. Finally, North Simcoe Muskoka has been approved for three new Nurse Practitioner–Led Clinics. The Clinics in Oro-

Medonte and at Georgian College are beginning to accept patients while the third Clinic recently awarded, to be located in Huntsville, is in the planning stages and will require outreach to populations in North Muskoka and East Parry Sound to meet the needs of residents.

Goal 2: Building Capacity & Improving Performance within the ER – All hospitals in North Simcoe Muskoka have actively engaged in strategies to improve ER performance. Pay for Results and the Emergency Department Process Improvement Program (ER PIP) were significant enablers of this improvement in the four participating hospitals. Muskoka Algonquin Healthcare and Georgian Bay General Hospital both implemented a LEAN approach to improve patient flow with Georgian Bay successfully completing ER PIP in December 2010. Collingwood General & Marine Hospital, Orillia Soldiers' Memorial Hospital and Royal Victoria Hospital all built on past successes working with LEAN and FLO. Four ERs in the region implemented Clinical Decision Units in the fall of 2010, two ERs have established "See & Treat" areas and several of the hospitals have worked with physicians to change schedules and practice patterns to improve the Time to Physician Initial Assessment. In November the Huntsville site of MAHC implemented a Physician Assistant-led fast track area to improve the flow of lower acuity patients. Organizations have implemented discharge lounges, bullet rounds, white boards, and numerous other initiatives across the organization to improve patient flow.

Goal 3: Improved Bed Utilization – Numerous new initiatives were funded in 2010/11 to continue to improve the flow of patients and reduce ALC days. Over the course of the year, 47 interim transitional care beds and 26 interim Long-Term care beds were opened across North Simcoe Muskoka. Planning for the future using an upstream approach to care, the North Simcoe Muskoka LHIN along with committed partners has begun the implementation of a Home First philosophy in the region. This philosophy is being accompanied by a Lean Six Sigma approach to process review as well as a substantial increase to both base and one-time North Simcoe Muskoka CCAC funding. In late 2010/11 and early into the next year of 2011/12, the region is implementing the Senior Friendly Hospital Strategy (SFHS) as part of the province-wide Healthy Communities: Healthy Seniors initiative. Complex Continuing Care (CCC) has been a major focus of North Simcoe Muskoka LHIN work over the past year with a LHIN-wide approach to CCC operations and care now moving forward. To move the SFHS and CCC agenda forward the LHIN is establishing interim SFHS and CCC System Coordinators. An Alternate Level of Care Working Group has been established to review and address consistent designation of patients, common definitions of patient designation, and processes for reporting this data thus improving the quality of the ALC patient date. Through improved data accuracy the LHIN will be able to better define the needs of patients designated ALC in this region. A Patient Flow Forum was hosted by the LHIN in fall 2010 with plans for another in spring 2011. This forum purposes the platform for area hospitals and the CCAC to discuss best practices and explore opportunities to collaborate to improve the flow of patients through the system. In 2010/11 supportive housing options in the Midland, Gravenhurst and Barrie area were expanded to better meet the needs of this region's aging population. Millcreek, a new 160-bed long-term care facility opened in Barrie in August 2010 thereby improving the ratio of long-term care beds available to residents and better aligning North Simcoe Muskoka with provincial averages. Home at Last continues to be a success in the region, facilitating discharge through home settlement services and associated follow-up. Recognizing the impact of end-of-life care, North Simcoe Muskoka is investing funding and planning time in supporting the advancement of palliative and hospice programming in the region, including the introduction of a LHIN-wide Palliative Resource Team and the continued success of Hospice Simcoe (10 beds).

GOALS and ACTION PLANS

Goal(s):

As per the North Simcoe Muskoka LHIN's ER/ALC Strategy there are three specific goals designed to impact ER/ALC.

- Reduce ER demand;
- Build capacity and improve performance within ERs; and
- Improve bed utilization by allocating patients to their appropriate level of care for their conditions.

Consistency with Government Priorities:

Ontario's ER Wait Time Strategy is focused on reducing the time people spend in the ER. The NSM LHIN ER/ALC Strategy aligns with the Ministry's priority of reducing ER wait times and improving ALC performance by:

- Expanding alternatives to ER services and provide patients with information on those options;
- Increasing capacity and improve processes within area ERs;
- Improving care processes and expand discharge options for ALC patients;
- Increasing community and home-based care options; and by
- Measuring and reporting ER and ALC performance as per Ministry requirements.

Action Plans/Interventions:

In 2011/12, the North Simcoe Muskoka LHIN will continue to implement the ER/ALC Strategy and monitor the impacts and outcomes of the investments as outlined in the previous section. The following table indicates the percentage completion of the action/plans interventions in each of the next three years.

Action Plans/ Interventions	2011-12	2012-13	2013-14
ER/ALC Strategy			
Revised ER/ALC Strategy	90%	5%	5%
Strategically, ER/ALC will be linked with the current LHIN Leadership Council and Local Leadership Council structure and a Committee / Group will be established to provide operational oversight to the LHIN ER/ALC strategic priority.	90%	5%	5%
Implementation of a Performance Monitoring and Reporting Framework to align with the ER/ALC Strategy (including Aging at Home and Urgent Priorities Funding)	65%	25%	10%
Development and implementation of a Communications & Community Engagement Framework to align with the ER/ALC Strategy (including a public media campaign regarding ER/ALC options)	50%	40%	10%
From the Care Connections plan (10 year), the review and implementation of recommendations from the Immediate Response Working Group will be built into the revised ER/ALC Strategy.	10%	25%	25%
Goal 1: Reduce ER Demand			
Implementation of a LHIN-wide Nurse Led Outreach Team into Long-Term Care	65%	25%	10%
Build local Health Human Resource capacity and increase access to primary care in Wasaga Beach and Midland through 2 new CHCs. (75% complete in 2010/11)	25%		
Support the development, integration and service capacity for the 3 awarded Nurse Practitioner-Led Clinics in North Simcoe Muskoka (10% completed in 2010/11)	50%	30%	10%
Goal 2: Build Capacity and Improve Performance within ERs			
Implementation and continued monitoring of the province-wide Pay For Results and ER Performance	33%	33%	33%

Improvement Program			
Goal 3: Improve Bed Utilization – Allocate Patients to the Appropriate Level of Care for their Conditions			
Implementation, monitoring and evaluation of the province-wide Transitional Care Program with the beds allocated for this purpose in North Simcoe Muskoka	33%	33%	33%
Implementation and evaluation of the Home First Philosophy in North Simcoe Muskoka	60%	30%	10%
In conjunction with the Care Connections plan and area of focus, continue the implementation and evaluations of the LHIN-wide Complex Continuing Care program. (60% completed before and in 2010/11)	30%	5%	5%
Development, implementation and evaluation of a LHIN-wide approach to the standardization of ALC patient designation, common definitions and reporting	50%	50%	
Implementation of the province-wide Senior Friendly Hospital Strategy, including local solutions	30%	40%	30%
Development, implementation and evaluation of an approach to reduce the percent of patients with an ALC length of stay (LOS) greater than 30 days	40%	50%	10%
Development, implementation and evaluation of an approach to reduce the percent of patients designated ALC within 48 hours of admission	40%	50%	10%

Describe how success will be measured:

Outcome measures and targets have been set to align with the ER/ALC Strategy. These have been based on the baseline performance as well as MLPA targets.

	ER / ALC Indicator	Baseline (2008/09)	Current Performance	Year 1 (2010-11) Target	Year 2 (2001-12) Target	Year 3 (2012-13) Target
GOAL 1: Reduce ER Demand						
1.1	**Hospitalized rate for ambulatory care sensitive conditions**	343.23	361.89 09/10 FY)	300	250	200
1.2	**Falls – related ER visits/100,000 population 65+**	6145.6	6141.7 (09/10)	5755.7	5560.8	5365.8
1.3	**Unscheduled ER visits/1,000 population**	534/ 1,000	127/1,000 (10/11 Q1) 523/1,000 (09/10)	525/1000	500/1000	490/1000
GOAL 2: Build Capacity and Improve Performance within ERs						
2.1	**Proportion of admitted patients treated within the LOS target of ≤8 rs.**	40.0%	56.1% (10/1 Q2)	46.0%	50.0%	50.0%
2.2	**Proportion of non-admitted high acuity patients (CTAS I-III) treated within their respective LOS targets of ≤8hrs for CTAS I-II and ≤6hrs for CTAS III.**	87.0%	87.9% (1 11 Q	92.0%	9 . %	95.0%
2.3	**Proportion of non-admitted low acuity patients (CTAS IV-V) treated within the LOS target of ≤4hrs.**	88.0%	90.3% (10/11 Q2)	93.0%	95.0%	95.0%
2.4	**Patient Satisfaction – ER atisfaction**	83% Positive 2 % Excellent	87% Po iti e / 4% Ex ellent 10 11 Q1)	85% Positive 25% Excellent	88 % Positive 30% Ex ellent	90% Positive 35% Excellent
GOAL 3: Improve Bed Utilization – Allocate Patients to the Appropriate Level of Care for their Conditions						
3.1	**% ALC days**	20.67%	20.01% (10/11 Q1)	15.4%	13%	9.5%
3.2	**ALC Length of Stay**	52 days	40 days (10/11 Q1)	45 days	40 days	30 days
3.3	**Median wait time to LTC home placement**	160 days	143 days (FY 09/10)	120 days	90 days	60 days

What are the risks/barriers to successful implementation?

Success in achieving the desired goals and outcomes related to ER/ALC are dependent on establishing mitigating strategies to risks or barriers. In particular, the North Simcoe Muskoka LHIN must be prepared to successfully manage:

- ***Significant and unexpected incidents which would put strain on the local health system, impacting ERs and/or ALC days.*** This would include incidents like outbreaks, pandemics and disasters. Recent experience with H1N1, the tornado in Midland and the G8 Summit in Huntsville provide a good foundation for the future. Newly established infrastructures, like the LHIN Leadership Council and the five Local Leadership Councils, provide forums to support the management of such incidents.

- ***Funding challenges which impact service delivery and sustainability.*** The volume of funding, the means of funding (i.e. one time funding vs. base funding) as well as the timing of funding announcements and funding flow all influence the ability of the LHIN and health service providers to successfully implement and sustain programs. As one way of mitigating these challenges the LHIN is establishing a more robust performance framework to which all funded programs will be held to account. To improve the quality of care and provide value add for the investment, reallocation of funding and integration of services are becoming increasing realities within the health care system. In addition, the establishment of a Decision-Making Framework supports a more transparent and better aligned process for funding decisions.
- ***Access to a sufficient number of appropriately qualified Health Human Resources impacts system leadership and service delivery.*** Recruitment and retention continue to be a challenge to service delivery, especially in rural areas and within specialized services. As such, the North Simcoe Muskoka LHIN has strengthened relationships with Georgian College, and the Northern Ontario School of Medicine. Technology options and creative solutions to service delivery continue to be explored to promote equity of access and quality care. A Health Human Resources group has also been established through Care Connections. Integration, LHIN-wide approaches to planning as well as shared resources are also being used to optimize scope of practice and skill sets within the region.
- ***Public, health service provider and system readiness for change (including patient self-management) which challenges program uptake and success.*** Transferring non-urgent care from the ER to a more appropriate care setting, moving toward a Home First philosophy and implementing an expanded role for Emergency Medical Services (EMS) all require a change in culture and practice with success contingent on readiness for change. Through Care Connections and a common vision for an integrated system of the future, the seeds for change are being planted. However the road ahead is long and requires patience and perseverance. Communication will be critical as will community engagement.
- ***Sustainability of programming after implementation.*** Programs like Pay for Results and Emergency Department Process Improvement Program are working to LEAN organizations and streamline processes but continue to struggle province-wide with sustainability. Organizations involved in such programs are being encouraged to share resources and collaborate through forums like the Patient Flow Forum to evolve and sustain programming. Ongoing planning in this area is required.

Chronic Disease Management - Access to Integrated Diabetes Care

Integrated Health Services Priority:

Improving chronic disease management beginning with access to integrated diabetes care.

IHSP Priority Description:

The NSM-LHIN has successfully aligned our Integrated Health Service Plan (IHSP) 2010-13, NSM Care Connections project and the Ontario Diabetes Strategy in order to effectively and efficiently address the needs and services of those living with or at risk of diabetes. The goals of the Diabetes Priority in North Simcoe Muskoka are to:

- Enhance the delivery of diabetes care; and
- Enhance the management and quality of diabetes care.

The NSM LHIN Leadership Council recently prioritized Chronic Disease Prevention and Management (CDPM) as an area of focus in the Care Connections plan stating that:

- There will be further advancement of a LHIN-wide model for Chronic Disease Prevention and Management by supporting initiatives with a diabetes focus.

Moving into 2011/12, there will continue to be a more focused strategy, along with the integration of the LHIN's system wide diabetes lead and the system planning and implementation that the NSM Regional Coordination Centre is accountable for. From this strong foundation in North Simcoe Muskoka, the streamlining of Ministry resources for the enhancement of self-management and diabetes care into will be critical for this success. Together building capacity and ensuring transparent communications will enable all parties to ***improve chronic disease management beginning with access to integrated diabetes care*** here.

Current Status:

Achievements – Demonstrating Investment into Action:

- Of the 7 diabetes education and management program sites in North Simcoe Muskoka, 4 additional full-time positions have been successfully recruited and are active in communities due to the investment of diabetes expansion teams. This includes the positions of 2 Registered Nurses and 2 Registered Dietitians.
- The NSM CCAC has a chronic disease functional team supportive of self-management practice.
- The College of Ontario Dietitians awarded a dietetic internship program for the NSM Area with a coordinator housed out of the Barrie Community Health Centre (CHC) and placement supports identified LHIN-wide.
- Two new Nurse Practitioner-Led Clinics (NPLC), one at Georgian College in Barrie and the other in Oro/Medonte, were awarded in 2009/10, and are in pre-operational status. In 2011/12 NSM stakeholders and residents will see improved access to care for the unattached and those at risk of and living with chronic conditions (diabetes) due to these investments.
- A third NPLC was awarded in 2010/11 to the community of Huntsville, which will meet the needs of those living in this more remote area with chronic illness. As development of this clinic continues, community partnerships will need to be established to ensure outreach is built into the service delivery model for residents in East Parry Sound and North Muskoka.
- The NSM Regional Diabetes Coordination Centre (RCC) has successfully staffed their team and identified membership to the LHIN Wide Steering Committee, which commenced meeting in January 2011.
- Two 0.5 FTE social worker positions were awarded to complement community diabetes

programs in the communities of Midland and Huntsville.

- The ReACT telemedicine program was awarded expansion funding through Aging At Home. This funding will ensure another 36 seniors in North Simcoe have access to remote vital signs monitoring.
- The Barrie CHC was successfully chosen as a member of the ODS provincial self-management working group. This opportunity allows the local voice on diabetes to be brought forward into provincial planning, thereby enhancing greater connectivity of the provincial work at the local level.
- 2010/11 Chronic Disease Prevention and Management – Diabetes was identified as one of the areas of focus in the Care Connections plan.
- A local knowledge exchange network of CDPM regional organizations was established (e.g., Diabetes RCC, Chronic Kidney Care, Osteoporosis, Arthritis, Stroke).
- A health and wellness community hub in Muskoka was established by the Algonquin Family Health Team (FHT) and community supporters. This new model is placed directly in the Huntsville community centre which allows for greater awareness and exchange, connection with community members of all ages and an opportunity to spotlight the services that can meet residents' needs.
- The diabetes expansion team based out of Orillia Soldier's Memorial Hospital with outreach services to the community of Gravenhurst, is experiencing drop-in rates averaging 25 clients per month.
- In Midland, a new Diabetes Team has been established. The team consists of one nurse, one dietitian, and one part-time social worker.

Identified Self-Management training needs for Diabetic Patients:

- Insulin pump management and mentorship
- Gestational diabetes, pregnancy and diabetes
- Management of diabetes medication
- Financial support for diabetics
- Mental health and diabetes management
- In hospital diabetes management
- Gastro paresis, renal care
- Managing diabetes during cancer treatment

Connecting Unattached Patients in North Simcoe Muskoka:

The Health Care Connect program refers people without a regular family health care provider to physicians and nurse practitioners who are accepting new patients in their community. As of July 31, 2009, there have been 173 matches of the 597 unattached registered residents in NSM since the program launched, February 12, 2009. NSM LHIN (May 2009-March 2010) was reported as having 188 individuals in the Health Care Connect database who self-identified as 'diabetes patients', which represented 7% of all individuals registered from NSM, of which only 76 had been referred to a physician. Having this data and information shared more regularly with the identification of diabetes patients is a huge success and will lead to continued monitoring and matching of residents to primary care in North Simcoe Muskoka.

Numbers of Diabetic Patients and their Outcomes:

As of December 2009, there are 1,044,622 individuals living with diabetes in Ontario, 32,217 of which are from the North Simcoe Muskoka LHIN. The crude prevalence rate for the North Simcoe Muskoka LHIN is 9.1%.

For those individuals living with diabetes in North Simcoe Muskoka:

- 48.4% (15,597) of diabetics received a blood glucose (A1C) test during the period of July to December 2009;
- 59.0% (18,992) of these individuals had their cholesterol level (LDL) tested during 2009;
- 64.8% (20,887) received a retinal eye exam in 2009; and
- 31.0% (9,974) of individuals living with diabetes in North Simcoe Muskoka had all the three of the above tests done during 2009.

GOALS and ACTION PLANS

Goal(s):

The NSM LHIN continues to establish and strengthen partnerships which support the following areas of focus (goals):

1. Enhance the delivery of diabetes care in NSM;
2. Enhance the management and quality of diabetes care in NSM;
3. The advancement of a LHIN-wide model for chronic disease prevention and management (CPDM)to support and focus on those with diabetes; and
4. The advancement of both local and provincial initiatives, with a focus on diabetes.

Action Plans/ Interventions:			
	2011-12	2012-13	2013-14
GOAL 1: Enhance the delivery of diabetes care in NSM			
Through the RCC, establish local diabetes networks / collaboratives in each of the 5 geographic areas with a physician lead established in each area.	100%		
All NSM CDPM service providers (with emphasis on diabetes related programs and services) will be linked to and profiled on Ontario211	75%	25%	
Improve the design of the delivery system for diabetes care through an integrated framework to enhance self-management practices/supports across the continuum of care.	35%	35%	30%
Implement a regional process (i.e., identification and referral) to improve access and awareness of self-management programs in NSM. (25% accomplished in 2010/11 Q4).	75%		
Build local Health Human Resource capacity and increase access to primary care, diabetes education and services in Wasaga Beach and Midland / Penetanguishene through the two new CHCs. (75% complete in 2010/11 with hiring of staff (including Francophone &	25%		

Aboriginal) and registration of clients).			
Goal 2: Enhance the management and quality of diabetes care in NSM			
NSM LHIN Diabetes Priority Lead, Support Team and eHealth representative are integrated into the NSM Regional Diabetes Coordination Centre Steering Committee and have aligned work plans to support deliverables in 2011/12.	75%		
Position for roll-out and implementation of the diabetes registry in NSM LHIN (monthly spreadsheet on readiness completed in 2010/11 – implementation focus for 2011/12).	75%	25%	
Performance monitoring of a diabetes care indicator in service accountability agreements/system performance with community sector HSPs.	Yr 1 of MSAA	Yr 2 of MSAA	Yr 3 of MSAA
Goal 3: Advance a LHIN-wide model for CDPM			
Develop a coordinating/advisory body that will drive the CDPM agenda forward	100%		
Advance the concepts and practice of personal skills and self-management supports beyond diabetes	50%	25%	25%
Design and deploy an integrated screening program, screening priorities and life stages for screening initiatives (broader than diabetes)	20%	30%	50%
Advance the Ontario Chronic Disease Prevention and Framework (2007) in several areas, for example: Delivery System Design and Provider Decision Support	20%	30%	50%
Goal 4: Advance local and provincial initiatives, with a focus on diabetes			
Support the integration and service capacity of 3 awarded Nurse Practitioner-Led Clinics in NSM (10% complete)	50%	30%	10%
Support the roll-out of the current Ontario Diabetes Strategy – expansion team initiative (80% complete 2009/10 4.0 FTE awarded and in place & 2010/11 1.0 FTE awarded).	20% in Q1		
Identification and enrolment of individual candidates for self-management support programs from those engaged in the ReACT telemedicine program	30%	30%	30%

Outcomes to Be Achieved:

- Integrated communications, work plans and resources between the Regional Diabetes

Coordination Centre staff and Steering Committee, the NSM LHIN Diabetes Lead and priority support team, the NSM eHealth diabetes lead, five LHIN Local Leadership Councils, the Ministry – ODS Implementation Branch, CDPM LHIN leads across the province and respective stakeholders (e.g., the Canadian Diabetes Association, the NSM Aboriginal Health Circle, local diabetes management centres, various primary care models and developing NPLCs).

- Utilization of Ontario211 as a method of creating awareness and increasing access to care for residents experiencing chronic illness and/or diabetes.
- Through self-management training, health service providers will enhance their capacity and knowledge required to implement and use self-management programming with patients. This will lead to increased confidence levels for diabetic patients to manage their own health and wellbeing.
- Analysis and continued reporting of LHIN level data on diabetes through eHealth Ontario, physician engagement in the Baseline Diabetes Dataset Initiative (BDDI), participation of NSM in the roll-out of the diabetes registry and Stocktake reporting on case mix groups (CMGs) on diabetes and related co-morbidities.
- Leverage five Local Leadership Councils, stakeholder champions and mentors – recognized for leadership in self-management – to support the achievement of LHIN and provincial CDPM (diabetes) goals.

Consistency with Government Priorities:

The NSM LHIN continues to support the Ontario Diabetes Strategy (ODS) targets of prevention, management and treatment of diabetes through the implementation of the CDPM area of focus in the Care Connections plan, support and roll-out of the Ministry Self-Management Project Funding, strategic alignment and integration of implementation activities with the local RCC and local LHIN level investment as required.

Our areas of focus in the Care Connections plan align with government priorities when we state that "there will be further advancement of a LHIN-wide model for Chronic Disease Prevention and Management by supporting initiatives with a diabetes focus."

Self-management education and supports are a focus of attention in NSM. As such, the Self Management Project funding aims to build local capacity amongst health service providers, dissemination and sharing of educational tools and knowledge transfer across providers system wide.

The NSM LHIN has a significant number (approximately 90%) of physician offices EMR ready, meaning that with the establishment of the NSM Diabetes Regional Coordination Centre, and the Diabetes Registry, the NSM LHIN is well on their way to provide leadership to improve health and care for the residents with diabetes and preventing those at risk from developing the disease.

Describe how will success be measured:

The key indicators of the NSM LHIN Diabetes Priority will be:

- The percent of NSM residents with diabetes
- The number of patients who have received a blood glucose control (HbA1C) test in the past 6 months
- The percent of patients who have a HbA1C <7 for 2 consecutive tests post self-management intervention
- Patients who have received a cholesterol (LDL-C) test in the past year (12 months)
- Patients who have received retinal eye exam in the past two years
- Patients who have received all three tests

This data will also be complemented with information gathered as a result of patient self-management programming in North Simcoe Muskoka.

Expected patient and health service provider outcomes as a result of the action items identified above are:

- Increased knowledge and skill enhancement of health service providers;
- Enhanced knowledge and ability of patients with diabetes to manage their own health and wellbeing;
- Enhanced access to regular screening and testing as they relate to diabetes management; and
- Improved physical activity and weight management by those residents living with diabetes in North Simcoe Muskoka.

What are the risks/barriers to successful implementation?

Success in achieving goals and outcomes related to diabetes access to care and management are dependent on mitigating the following risks/barriers:

- The Ministry and the LHINs, along with the Regional Coordination Centres need to work together to ensure a unified approach for effective resource utilization to build capacity and service coordination across the continuum.
- Human capital – access to and availability of trained health service providers to direct care and support services to individuals at risk of and living with diabetes is a critical success factor;
- The readiness of both residents/patients and providers, including physicians to utilize the online diabetes registry needs to monitored and evaluated for implementation success;
- Acquiring measurable indicators at a LHIN and local geographic level with available baseline data for comparison over time is a must for the continued growth and achieved outcomes for integrated diabetes care;
- The identification, monitoring and successful attachment of patients with diabetes to an available / accessible primary care provider locally will continually demonstrate results; and
- As pressures increase with an aging population with more complex care needs (e.g., multiple co-morbidities, medications, etc), who require more provider time (visit duration), and are on wait lists for service, there will be a need to triage clients more effectively and efficiently through system design, knowledge exchange and system navigation.

Designing an Integrated Future State of the Health System in North Simcoe Muskoka (Care Connections Plan)

Integrated Health Services Priority:
Creating an Integrated Design for the Future Health System in North Simcoe Muskoka (Care Connections Plan)
IHSP Priority Description:
Care Connections Vision: *A healthy population supported by the North Simcoe Muskoka health system - a respectful, accessible, and coordinated collection of health services that, when needed, offers the necessary care and works with people to help them manage their own health.* *A health system optimizing the use of our collective resources to promote a healthy and supportive environment, taking care of people when they become ill and helping them maintain better health through all stages of life.* The Integrated Health System Design (IHSD), known as Care Connections – Partnering for Healthy Communities is a 10-year strategic plan that outlines how to collectively realize this vision. Informed by the results of nine working groups, the plan includes models of care, service delivery approaches with associated short, medium and long-term recommendations, and a transformation model to guide implementation. These initiatives will include: improving the health of the population through increased access and quality of care; enhancing the use of collective resources through streamlined processes and collaboration; and producing system-wide savings. While these collective initiatives will take place over the next 10 years, short-term (over years 1-3) areas of focus will build upon existing momentum, identify significant areas of need, and contribute to system-wide progress. Led by a Steering Committee of Senior Administrative and Clinical Executives known as the NSM LHIN Leadership Council, the plan was developed over a 10 month period by multiple stakeholders; LHIN funded health service providers (HSPs) and non-LHIN funded organizations representing all sectors across the continuum of care. Several organizations whose primary mandate relates to other determinants of health were included in order that a fully integrated health system design is achieved. Over 350 persons contributed in excess of 20,000 hours of their time, engaged in facilitated working sessions using "best available" data/information, leading practices and expertise within their particular area of care in Ontario and other jurisdictions. The plan also takes into consideration system enablers required to support the implementation and evaluation of programs and services in achieving better health, better care and better value. In response to needs identified through broad stakeholder engagement which began in 2005/06, the plan will provide a system of coordinated health and health care services that include provider, self-care and provider/self-care co-managed options. These options are aimed at keeping people healthy and taking care of them when they become ill. The plan provides for a supportive environment to help create a healthier population able to maintain better health through all stages of life.

The Care Connections Plan sets out:

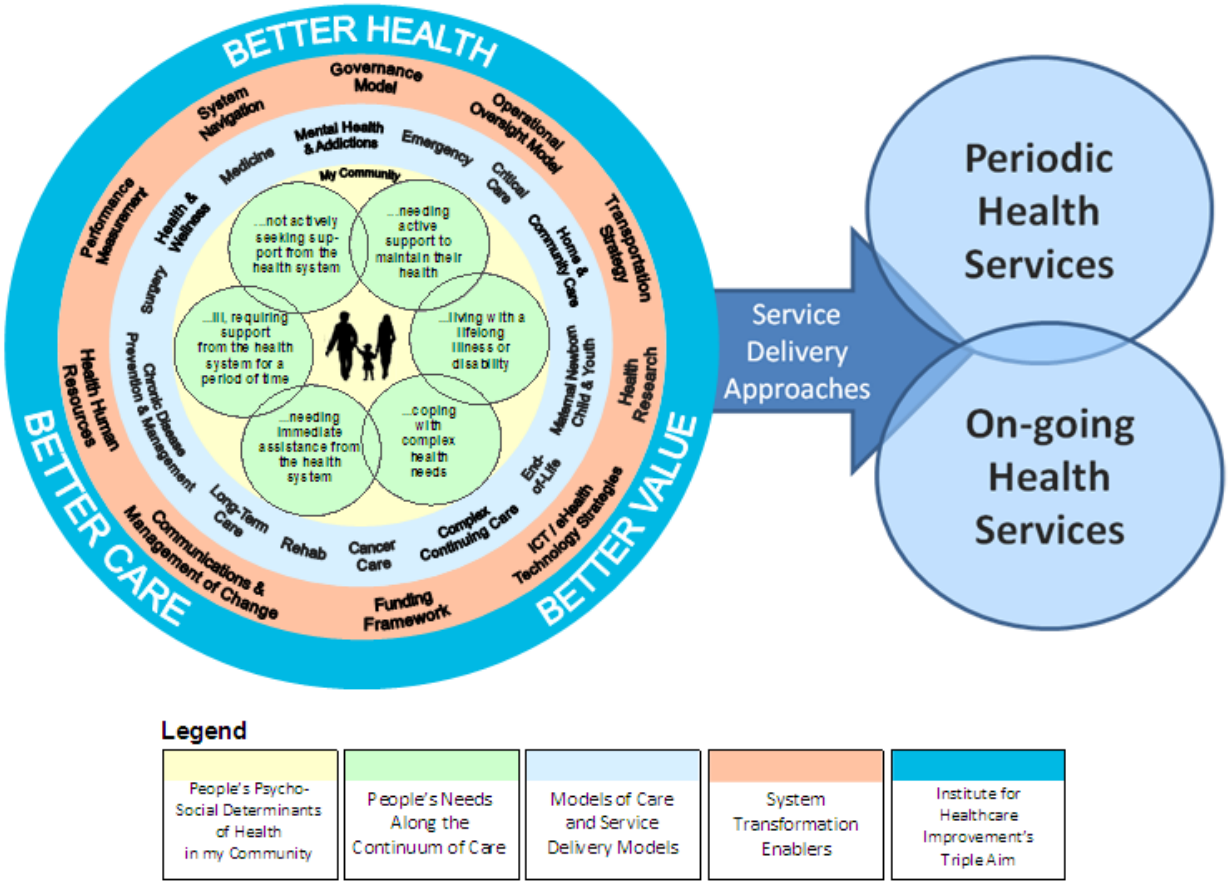
- How individuals and their support systems (partners, families, communities in which they live) will access services and navigate through the integrated system to receive timely services in five geographic areas as close to home as appropriate.
- How people and providers will access information, (education, consultation and information sharing).
- How people will receive care (entry points for monitoring and maintaining health, screening, and intervention through standardized coordinated models of care).
- How care will be organized across the LHIN and coordinated with services throughout the province, when necessary; future health services delivered through one, or a combination of two integrated service delivery approaches: (1) periodic health services; and (2) on-going health services. Based on the level of specialization, these services are either in each of the five local geographic areas or clustered into a LHIN-wide service delivery model. All services requiring a level of specialization beyond the capacities of a LHIN-wide program or service will be referred to partner organizations across the province.

Over 400 recommendations across 9 clusters of programs and services have been developed. These recommendations will guide the work plans established in each of the clusters over the next 10 years.

Over the first 3 years (2010/11-2012/13), implementation plans for twelve identified "areas of focus" will be created and deployed utilizing, where possible, existing resources in the system. To enable implementation and provide stability and sustainability of the integrated health system, frameworks have been developed for governance, operational oversight, system navigation (including transportation), funding, a multi-disciplinary and inter-professional health human resource plan and communications plan including a change management strategy. An Information Communication Technology/eHealth (ICT) 3-year strategy has been created for the development of an ICT infrastructure and business solutions required in each of the areas of focus.

The *system transformational model* (seen on next page) represents the elements of the future integrated health system design. These elements are centered around the individual and their supporting communities including various health disciplines and the enabling tools/processes that yield two service delivery approaches: i) those who require health services periodically; and ii) those who require health services on an on-going basis.

System Transformation Model



Legend

People's Psycho-Social Determinants of Health in my Community	People's Needs Along the Continuum of Care	Models of Care and Service Delivery Models	System Transformation Enablers	Institute for Healthcare Improvement's Triple Aim

Current Status

The 10-year plan is documented in the Care Connections – Partnering for Healthy Communities Report (which is currently being finalized).

By the end of February 2011, completion of further stakeholder engagement on the future integrated health system design will be completed. Recommendations on each component of the plan will be forwarded to the NSM LHIN Board by the LHIN Leadership Council, for consideration and approval.

Prior to April 1st 2011, organizational oversight and planning groups comprised of system-wide stakeholders relative to each 'area of focus' will be organized to begin implementation planning for all recommendations approved by the LHIN Board. Alignment of each with existing NSM LHIN initiatives, provincial priorities and business requirements are to be determined through this process. During the first quarter of the 2011/12 fiscal year, the Care Connections plan for years 1-3 will be launched.

GOALS and ACTION PLANS

Goal (s)

The primary goal of the North Simcoe Muskoka LHIN is to create an environment of support for and facilitation of transformation to an integrated health system. In alignment with the other two LHIN priorities, further advance implementation planning and monitoring of action plans for each area of focus will occur. System enablers as outlined below will ensure success in achieving elements of the integrated system design vision. Ongoing communications, engagement of stakeholders and management of change will be critical to the success of each program and service.

The Areas of Focus and goals for the first three years of the 10-year plan include:

Surgery

1. Advancing the LHIN-wide management of bone/joint care (Orthopaedics).

Medicine

2. Implementing the LHIN-wide Critical Care model

Complex and Chronic Needs

3. Implementing the Complex Continuing Care recommendations at a 3-site LHIN-wide program
4. Advancing LHIN-wide model for Chronic Disease Prevention and Management by supporting initiatives with a diabetes focus
5. Implementing the Behavioural Support Service model to better care for this specialized population
6. Building in-home and community capacity to support people to live at home as long as possible

Mental Health and Addictions

7. Redistributing Schedule 1 mental health beds from Mental Health Centre Penetanguishene to 3 sites – 2 existing and one new site
8. Building child and adolescent mental health capacity in the NSM LHIN
9. Enhancing crisis management and community resources for mental health and addictions

System Enablers

10. Implementing the ICT/eHealth enabling strategy (infrastructure and business solutions to bring all sectors to a baseline of connectivity and technological advancement)
11. Developing a workforce planning strategy and process that includes a comprehensive data collection and review process to inform detailed system-wide HHR data, and LHIN-wide recruitment and retention plan that considers pending program expansions and future HHR needs
12. System Navigation beginning with collaborating with municipalities and transportation service providers, expanding non-urgent and other transportation systems across the NSM LHIN

It is important to note that while these initiatives focus on the next three years, there are inter-dependencies between initiatives and progress in one area that will likely impact another. In addition to these areas of focus, current initiatives will continue to evolve. Over the years, the plan will accommodate the evolving future needs of those we serve, as well as local and provincial identified priorities.

Consistency with Government Priorities:

The North Simcoe Muskoka Integrated Health System Plan, Care Connections – Partnering for Healthy Communities is in alignment with the following provincial priorities:

- Government of Ontario Plan 2020 (draft), with focus on the vision and transformation agenda.
- Excellent Care for All Act, June 2011
- Rural and Northern Care Framework/Plan; Stage 1, MOHLTC, Jan 2011
- Report by the Select Committee on Mental Health and Addiction, Aug 2010
- Ontario Cancer Plan, 2011 – 2015, Cancer Care Ontario (CCO), Nov 2011
- Preventing and Managing Chronic Disease, Ontario's Framework, MOHLTC, May 2007
- Ontario Public Health, Healthy Communities Project, 2011

Action Plans/Interventions

Description	2011-12	2012-13	2013-14
Phase 1: Implementation Planning: *a) Through the NSM LHIN Leadership Council (LHIN LC), establish lead Organizational Oversight for each of the twelve areas of focus that define ownership (accountability and responsibility) for deliverables related to each of the following areas of focus in years 1- 3.* *b) Align NSM LHIN staff and other resources to support each of the organizational oversight bodies.* *c) In collaboration with the Operational Oversight structures, align Care Connection implementation plans with provincial priorities, as noted above.* *(Note: 100% completion in 2010/11)*	See note in previous column		
Phase 2: LHIN-wide Program/Service Monitoring: *a) Through the LHIN CEO and LHIN LC, and in collaboration with provincial bodies (e.g., Ontario Quality Health Council, Cancer Care Ontario, etc.) monitor implementation of standards and process/outcomes measures associated with each 'areas of focus'.* *b) Establish agreement on benchmarks and targets related to each deliverable in each of the plans,* *c) Monitor and report progress via balanced scorecard and quarterly reports through the LHIN LC to Local Leadership Councils (LLCs) and integrated health system partners.* *(Note: 50% completed in 2010/11)*	25%	25%	

Phase 3: Funding of LHIN HSPs and new initiatives / provincial priorities: *a) Align portion of total funding ($750M) distributed across LHIN-funded organizations to support integration initiatives* b) *Establish revised annual accountability agreements with performance metrics to reflect evidence of improvements in service delivery across the local geographic areas and in alignment with the system transformation model.*			100%
Phase 4: **Integration of Programs/Services:** *a) Support, monitor effectiveness, and evaluate outcomes related to all integrations occurring within the areas of focus through:* • *LHIN Board agreements on integrations, where appropriate,* • *LHIN review of annual quality improvement plans as they relate to outcomes on better health, better care, and better value,* b) *LHIN reporting on integration initiatives through Stocktake or other means required by the MOHLTC. (Note: 25% completed in 2010/11)*	25%	50%	
Year 4 – 10 Planning and Implementation a) *Review, monitor and evaluate success of Year 1-3 initiatives to then base the planning and implementation for Year 4-10.*	20%	30%	50%

Expected Impacts of Key Action Items

Implementation of the Transformation Model utilized to integrate the health system in North Simcoe Muskoka, is expected to produce better health, better care and better value for the people residing and visiting the NSM LHIN.

Through implementation of twelve areas of focus over the first three years of the Care Connections Plan, the HSPs and their non-LHIN funded partners will be able to:

- Define specific performance measures,
- Assess system changes and their effects on the health and care of people in NSM,
- Inform and provide better access to appropriate health and health care services across the continuum of care when and where (location) needed, and be supported in managing their own health,
- Enable health system partners to collaborate regularly and share patient information securely, using integrated information systems and technology,
- Determine the demand for those services, their costs, and where they are best delivered, so funding can be allocated effectively.

What are the risks/barriers to successful implementation?

Successful implementation of the areas of focus established for the first three years depends on the commitment to transformational change by all persons across the system. All stakeholders, including the public, will need to be clear on their specific roles and responsibilities required to build a functional integrated system. Risk or barriers to successful implementation will largely be due to non-performance of the following roles:

NSM LHIN in Collaboration with its Health System Partners:

- Developing future Integrated Health Service Plans and accountability agreements aligned to the vision of the Integrated Health System
- Developing and empowering oversight structures to facilitate the implementation of the future system
- Developing a transparent funding allocation and performance measurement process as defined by the system-wide funding framework
- Supporting health service providers and partners to work towards the shared integrated health system vision and models
- Facilitating transparent communication processes to enable easy collaboration

LHIN Board and Health Service Provider Boards:

- Facilitating collaboration of LHIN funded and non-LHIN funded Boards:
  - To create support for the Care Connections Operational Oversight models
  - To develop on-going outreach and engagement to develop education on governance roles and responsibilities in an integrated health system
- To inform all parties on local planning area perspectives as project implementation related to Care Connections takes place
- Providing direction for Board leadership to balance organization-specific accountabilities and collaborative initiatives (e.g. Memorandums of Understanding)
- Providing clear indication of support and direction through agreements with collaborating organizations to create shared accountabilities (HSAA, MSAA, etc.)
- Continuing progressive discussions and developing agreements with the Ministry of Health and Long-Term Care, Ontario Medical Association and others on new funding models to support inter-professional care models. Regulatory bodies which govern health professions will also need to be consulted regarding any changes required to facilitate the implementation of inter-professional care models.

LHIN-Wide Operational Oversight:

- Having accountability and providing leadership with responsibility for implementation, coordination, capacity building, performance measurement and evaluation
- Providing direction for initiatives as they align to the overall *Care Connections* implementation plan
- Coordinating local geographic area and LHIN-wide priorities to align to provincial/national mandates
- Fostering a culture and mechanism for knowledge and information-sharing among providers and individuals
- Evaluating and monitoring progress of LHIN-wide programs/services at a system and local level

Health Service Providers and Health Care Professionals:

- Seeking opportunities to integrate the health system in alignment with the implementation plan
- Transforming leadership relationships to facilitate and oversee system-wide change

- Fostering success in all NSM organizations
- Supporting each other to realize an improved system-wide integrated Health Human Resource plan

LHIN Operations and Staffing

NORTH SIMCOE MUSKOKA LHIN OPERATIONS AND STAFFING					
LHIN Operations Sub-Category ($)	**2009/10 Actuals**	**2010/11 Allocation**	**2011/12 Planned Expenses**	**2012/13 Planned Expenses**	**2013/14 Planned Expenses**
Salaries and Wages	***1,937,963***	***2,288,316***	***2,509,398***	***2,584,680***	***2,662,220***
Employee Benefits					
HOOPP	182,736	228,832	250,940	258,468	266,222
Other Benefits	278,327	274,641	301,128	310,162	319,466
Total Employee Benefits	***461,063***	***503,473***	***552,068***	***568,630***	***585,688***
Transportation & Communication					
Staff Travel	49,220	52,000	61,200	62,500	63,800
Governance Travel	16,414	22,000	15,000	15,000	15,000
Communications	50,302	51,000	58,550	59,750	61,000
Other Benefits	92,950	50,000	25,000	25,500	26,000
Total Transportation and Communication	***208,886***	***175,000***	***159,750***	***162,750***	***165,800***
Services					
Accommodation	176,813	184,458	189,000	193,000	197,000
Advertising	20,926	10,000	10,000	10,000	10,000
Consulting Fees	522,886	300,000	275,000	275,000	275,000
Equipment Rentals	7,490	7,800	8,000	8,300	8,600
Insurance	14,345	15,398	16,000	16,500	16,500
LSSO Shared Costs	310,898	312,000	312,000	312,000	312,000
LHIN Collaborative Structures	12,286	50,000	50,000	50,000	50,000
Board Chair's Per Diem expenses	73,150	57,300	50,000	50,000	50,000
Other Board Members' Per Diem expenses	32,900	43,225	34,000	34,000	34,000
Other Meeting Expenses	55,145	60,000	57,500	58,650	60,000
Other Governance Costs	6,581	32,685	35,000	35,000	35,000
Printing & Translation	26,419	45,000	56,000	57,000	58,000
Staff Development	42,931	70,000	75,380	78,392	80,741
Total Services	***1,302,770***	***1,187,866***	***1,167,880***	***1,177,842***	***1,186,841***

Supplies & Equipment					
IT Equipment	94,412	20,000	40,000	40,000	40,000
Office Supplies & Purchased Equipment	50,370	45,500	44,000	45,000	46,000
Total Supplies and Equipment	***144,782***	***65,500***	***84,000***	***85,000***	***86,000***
Capital Expenditures	***248,864***	***150,000***	***35,000***	***35,000***	***35,000***
LHIN Operations: Total Planned Expense	**4,304,328**	**4,370,155**	**4,508,096**	**4,613,902**	**4,721,549**
Annual Funding Target			**4,508,096**	**4,613,902**	**4,721,549**
Variance			-	-	-

NORTH SIMCOE MUSKOKA LHIN STAFFING Position Title	2010/11 Actuals as of Mar. 31/10 FTEs	2010/11 Forecast FTEs	2011/12 Forecast FTEs	2012/2013 Forecast FTEs	2013/2014 Forecast FTEs
Administrative Assistant	1	1	1	1	1
Executive Assistant	1	1	2	2	2
Program Assistant	2	2	2	2	2
Office Assistant / Scheduler	1	1	1	1	1
Executive Coordinator	1	1	1	1	1
Senior Director Health System Performance, Measurement and Integration	1	1	1	1	1
Director, Integrated Health System Design Project	1	1	1	0	0
Senior Manager, Health System Integration	1	1	1	1	1
Senior Manager, Health System Performance and Measurement	1	1	1	1	1
Senior Manager, Health System Planning and Development	1	1	1	1	1
Senior Planner, Health System Planning & Development	2	2	2	2	2
Senior Analyst, Health System Performance & Measurement	1	1	1	1	1
Planner, Health System Planning & Development	1	1	1	1	1
Analyst, Health System Performance and Measurement	2	2	2	2	2
Performance Support, Health System Performance & Measurement	0	0	0	0	0
Planning Coordinator, Health System Planning & Development	1	1	1	1	1
Senior Director Finance and Risk Management	1	1	1	1	1
Senior Consultant, Funding & Allocation	0	0	0	0	0
Senior Consultant, Funding & Risk Management	1	1	1	1	1
Controller	1	1	1	1	1
Funding & Allocation Consultant	0	0	0	0	0
Analyst, Funding & Risk Management	1	1	1	1	1
Chief Executive Officer	1	1	1	1	1
Manager, Communications & Community Engagement	0	0	1	1	1
Communications Coordinator	1	1	1	1	1
Manager, Organizational Talent and Corporate Services	1	1	1	1	1
French Language Services Coordinator, Health System Planning & Development	1	1	1	1	1
Administrative Assistant, eHealth	1	1	0	0	0
CIO / eHealth Lead	1	1	1	1	1
LHIN Project Coordinator – eHealth	1	1	1	1	1
Senior Project Manager – eHealth	1	1	1	1	1
Total	**30**	**30**	**30**	**29**	**29**

Communications Plan

Objectives: What is the purpose of the ABP?

The ABP is one of three guiding documents that are critical to the work of the North Simcoe Muskoka LHIN. The other two documents are the Care Connections – Partnering for Healthy Communities Report (currently being finalized) and the Integrated Health Service Plan 2010-13 (IHSP).

The Care Connections Report contains care model recommendations and details on their frameworks that were developed by over 350 stakeholders - physicians, nurses, allied health professionals, administrators. All the recommendations and frameworks are aligned with the vision of "Partnering for Healthy Communities" to provide quality, accessible, sustainable health care to the residents of the North Simcoe Muskoka LHIN.

The IHSP guides the activities and accountabilities of local health service providers as described in the Local Health System Integration Act, 2006. Specifically, it provides an overview of the current health system, identifies areas for focused improvement and sets standards for achievement. All of this is done to advance the North Simcoe Muskoka LHIN IHSP vision of *"Working Together to Achieve Better Health, Better Care, Better Value."*

The ABP demonstrates progress made toward reaching the IHSP's three strategic goals of:

- Improving access to appropriate care, beginning with the emergency room and alternate level of care settings in the community or home
- Improving chronic disease management, beginning with access to integrated diabetes care
- Creating an integrated design for the future health system in North Simcoe Muskoka

It also provides the opportunity to fine tune strategies for the upcoming year. It provides a framework for communicating to stakeholders the impact local decision making has on health care delivery in local communities.

Context: Why do we do an ABP?

Under the Agency Establishment and Accountability Directive LHINs are required to produce and publish a business plan annually. LHINs are required to inform stakeholders about the LHIN's strategies and initiatives for addressing IHSP priorities. The North Simcoe Muskoka LHIN's ABP communication plan ensures that all stakeholders have full and easy access to the strategic and operational plans.

The document also includes an overview of the activities to support key provincial activities and a management plan to identify the future challenges faced by the health system. LHINs are responsible for engaging health service providers, consumers, and the general public in the work that is required to build an accessible and sustainable quality health system.

The ABP also provides LHIN funding requirements for the next three years with particular focus on the 2011-12 fiscal year.

Target Audiences Include:

- MOHLTC
- Other LHINs
- Government stakeholders
    - Municipal; Regional; Provincial; and Federal
- North Simcoe Muskoka LHIN Partners
    - LHIN Leadership Council and five Local Leadership Councils
    - French Language Health Planning Entity
    - Aboriginal Health Circle
    - Working Groups
    - Governance Working Group
    - NSM LHIN Communicators Group
    - North Simcoe Muskoka Diabetes Network
    - North Simcoe Muskoka Human Resources Steering Group
    - Health Professionals Advisory Committee (HPAC)
    - Public Health Leads
    - North Simcoe Muskoka LHIN Provider-based committees
- Individuals who have indicated an interest in North Simcoe Muskoka LHIN activities
- Health Service Providers/Stakeholders
- Health Service Providers Leadership and Front Line staff (including union leadership)
- North Simcoe Muskoka Health Service Provider Boards
- Patients/Clients/Consumers/Residents
- Consumer/Patient Support Groups
- General Public
    - Residents; Citizens; and Service Clubs
- Media

Strategic Approach: What type of announcement?

Coordinated, same day release of ABP document for all LHINs (date tbd).

Morning – LHINs to notify their provider/stakeholder groups

Afternoon – LHINs post on individual web sites. LHINs could issue local news release (optional)

Inclusion of ABP Goals and Action Plan in all on-going communication and community engagement activities

Tactics:

- Communication Partnership – LHIN Communication Leads
- Communication Partnership – North Simcoe Muskoka LHIN Communication Network
- Developing strong local Government Relations
- Communicating with Physicians
- Communication between LHIN Leadership and Local Leadership Councils
- Maintaining strong Media Relations
- Enhancing the Speakers Bureau
- Organizing Knowledge Building/Information Sharing Events
- Maintaining a consistent toolbox of strong communication vehicles
    - *2009-10 Annual Report; News Releases; and Blast Emails*
    - *North Simcoe Muskoka LHIN Website*
        - Public Site
        - Collaboration work spaces (to be developed)
- Electronic newsletter – Monthly
- Calendar