

North Simcoe Muskoka Local Health Integration Network

"Healthy People. Excellent Care. One System."

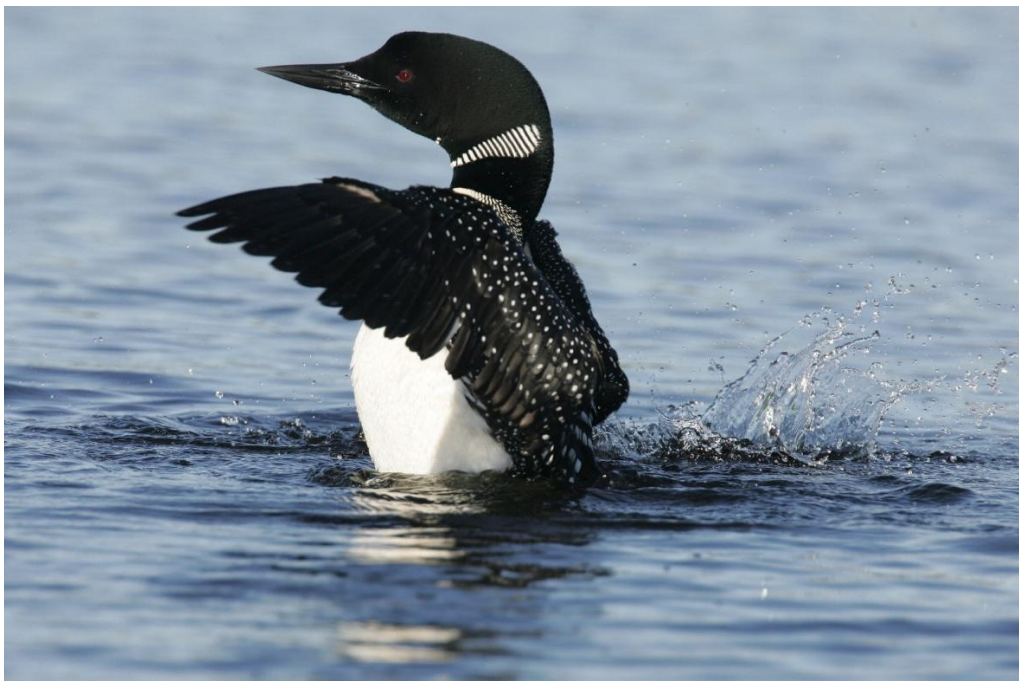
"Une population en santé. D'excellents soins. Une structure unifiée."

Annual Business Plan 2012 - 2013



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North Simcoe Muskoka LHIN – Annual Business Plan Context

Mandate and Strategic Directions

The Local Health Integration Network (LHIN) is a regional organization that helps health system partners pull together as one. 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 North Simcoe Muskoka's 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**
(branded as *Care Connections – Partnering for Healthy Communities*).

The North Simcoe Muskoka (NSM) LHIN Care Connections ten-year integrated health system plan (2010 – 2020) is re-examining and realigning the local health system through a fully collaborative process with all local stakeholders – residents, people with lived experiences, their families and caregivers and many health professionals from across the continuum of care. Care Connections continues to be the foundation of how the LHIN will work together with health system partners to achieve the vision while improving population health (Better Health), the patient experience (Better Care) and sustainability of the health system (Better Value) over the next ten years.

The vision for meeting the needs of our residents, our population, now and in the future is one that looks forward to a sustainable health system that is accessible, seamless and easy to navigate no matter where and when an individual requires wellness or disease care across the continuum of services. We will achieve the vision of **Healthy People, Excellent Care, One System**. through shared accountability and ownership across health system partners enacting the mission of **Together...Achieving Better Health, Better Care, Better Value** for North Simcoe Muskoka's health system. To reach this, transformative leadership by health system partners is a key factor to successfully integrate system-wide change and by living the values to **Be Real (Engage with Purpose). Be Courageous (Model the Way). Be Revolutionary (Explore the Possibilities)**.

Overview of NSM LHIN Current and Forthcoming Programs / Activities

The North Simcoe Muskoka LHIN funds 77 health service providers which spans the entire health care continuum in North Simcoe Muskoka. In 2012/2013, we will allocate approximately \$781 million to the following local health system organizations and/or specific programs:

- 7 Hospitals
- 1 Community Care Access Centre (CCAC)

- 26 Long-Term Care Homes (LTC)
- 3 Community Health Centers (CHC)
- 31 Community Support Service Organizations (CSS, ABI & ALSSH)
- 9 Community Mental Health Agencies (MH & Addictions)

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. While doing so, we must develop sound integration strategies that will address the LHIN's legislative obligations of addressing the health equity needs of the Francophone and Aboriginal communities.

Equity is recognized as a key component of quality care and effective service design and delivery – *the right care, in the right place, at the right time*. Equity has been defined by the Ministry within the health system, as reducing systemic barriers to equitable access to high quality health care for all; addressing the specific health needs of people along the social gradient, including the most health disadvantaged health populations; and ensuring that the ways in which health services are provided and organized contributes to overall health disparities. Addressing health equity in North Simcoe Muskoka can make a critical contribution to health system sustainability by reducing the incidence of costly and preventable illness and related treatments.

French Language Services

The divestment of French Language Health Services from the Ministry of Health and Long-Term Care and the migration of the French Language Services (FLS) Coordinators from health service providers (HSPs) were completed in July 2010. The fourteen LHINs have established a provincial French Language Services Coordinators Network to help ensure a coordinated approach to planning, implementation and integration to the French Language Services across the province. The North Simcoe Muskoka LHIN is the lead LHIN for this Network and plays a leadership role with the collaboration of colleagues.

The LHIN French Language Service Coordinators have been structured into this network which will address a number of responsibilities including:

1. Creation of sub-committees to work on specific Network tasks;
2. Development of a FLS accountability framework for LHINs and HSPs, including planning and reporting requirements and tools;
3. Share FLS best practices and identify options for resolution of key issues related to the implementation of FLS in the LHINs and HSPs;
4. Assist in the development of FLS key performance measures;
5. Recommend strategies and operational processes to guide the work of the LHINs;
6. Develop a common set of tools;

7. Develop a framework to effectively address complaints of the French Language Services Commissioner relating to local health systems;
8. Develop and/or provide input into a common reporting format for Francophone community engagement activities, as per the Regulation on French Language Health Planning Entities.

French Language Health Planning Entity

Improving French Language Services for the Francophone community will be undertaken in partnership with the newly created provincial Centre South-West French Language Health Planning Entity (FLHPE#4) which is mandated to work with the Central, Central East and North Simcoe Muskoka LHINs to strengthen the engagement of, and health outcomes for the Francophone community within these regions. The terms of this partnership are outlined in the Service Accountability Agreement between the Entity and the three LHINs and are supported by a collaborative spirit of shared purpose to improve health outcomes for local Francophone residents.

In 2012-13 the LHINs and Entity will continue to build on the current Joint Action Plan that identifies the following five priorities:

1. Continue with strengthening the operational capacity of the Centre South-West French Language Health Planning Entity;
2. Further clarify roles, responsibilities and working relationship of the Entity and the LHINs;
3. Engage the Francophone community on actions taken by each LHIN to achieve the Integrated Health Service Plan strategic priorities with regards to:
 - The diversion of patients / individuals from Emergency Rooms (ER) to appropriate health service providers in the community;
 - The improvement of patients / individuals being able to access the appropriate care, in the appropriate place at the appropriate time in the community to achieve the decrease in the number of Alternate Level of Care (ALC) days in hospitals;
 - The improvement of patient / individual access to care through increased capacity for the self-management of diabetes for those at risk of or living with diabetes; and
 - Collect data and information on the Francophone community's use of the health services applicable to the above LHIN strategic priorities.
4. Make information on French Service Providers easily accessible on websites of each LHIN and the Entity; and
5. Identify long-term (4 years) goals for improving access to French Language Services in each LHIN.



Aboriginal Health Services

Improving Aboriginal Health Services will be undertaken in collaboration with the local Aboriginal Health Circle (AHC) and supported by the Aboriginal Health Services LHIN Lead.

The mission of the Aboriginal Health Circle is to work in partnership with the North Simcoe Muskoka Local Health Integration Network to improve the health status of Aboriginal people in the North Simcoe Muskoka region.

The Aboriginal Health Circle meets on a regular basis to collaborate efforts to address Aboriginal community health issues in systems coordination and integration. It will accomplish this through working in partnership with member communities, agencies and the NSM LHIN to address the goals and objectives that have been established for the Aboriginal Health Circle.

Integrated Health System

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; therefore achieving the vision *Healthy People, Excellent Care, One System*.

To make system-wide changes successful, we have developed a plan to guide how we distribute and integrate services. The Care Connections integrated health system 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 remaining 9 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, and in order to achieve this, we are enhancing the developed 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?

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;
- *People* will get the right level of care in the community as there will be a stronger, more supportive network of community services;
- *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;
- *People* at risk of or living with chronic disease will know how, where and from whom to get the care and services they need; and
- *People*, families, caregivers and the community will value education and illness prevention.

Better Care

- *People's* needs will be the focus as health system partners pull together, performing as a single, coordinated and integrated system;
- *People* will get appropriate care as hospital beds will be more readily available when needed;
- *People* with chronic disease will become better self-managers;
- *People* will find it easier to get consistent and high quality care throughout the local health system, in home and in the community;
- *People* will better understand their health status as eHealth / technology will be widely available and utilized as health service professionals, providers and partners will be brought

to a state of readiness of meeting technological needs and electronic system enablers to make this change real.

Better Value

- *People* will be better educated in preventing and managing chronic disease, thus reducing the personal and system costs of diseases;
- *People* will see efficiencies in the system as the utilization and demand for service across the region will be reviewed to help us understand where services are duplicated, how to avoid waste and deliver services better; and
- *People* will receive the right care in the right place at the right time as strategic investments and shifting of resources will help improve capacity and performance in the system across the continuum of services.

The North Simcoe Muskoka Local Health Integration Network Annual Business Plan for 2012-2013 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 implement the integrated health system plan for North Simcoe Muskoka.

Environmental Scan



Population of North Simcoe Muskoka

Population estimates for 2010, as prepared by the Ontario Ministry of Finance indicate that the North Simcoe Muskoka LHIN had a base population of 455,701, representing approximately 3.45% of Ontario's total population and a 1% increase from the previous year. 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 create demand for health services. North Simcoe Muskoka is also growing and aging faster than the province as a whole.

- From 2001 to 2009, the population in the NSM LHIN catchment area (as derived from population estimates prepared by the Ontario Ministry of Finance) rose by 15.1%, while the net increase to the Provincial population rose by a more modest 9.8%, during the same time period. By 2020 the overall population is expected to grow by approximately 35.2% in North Simcoe Muskoka, as compared to 2001 census population figures. This compares significantly to the Ontario Population estimates for the same time period, in which overall growth is expected to reach 25.2%, a full 10% less than that expected to be experienced in North Simcoe Muskoka.
- In 2011, seniors aged 65+ in the NSM LHIN accounted for 14.1% of the total population, which mirrors that of the province. By 2020, the NSM LHIN will have the fifth greatest growth rate of seniors as compared to all other LHINs in the Province. This growth of seniors will place more demands on health care services in the Region.
- The area'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 achieve the vision of *Healthy People. Excellent Care. One System.* through managing change and behaviours to integrate the health system by living the values to *Be Real. Be Courageous. Be Revolutionary.*

Be Real – Engage with Purpose

- Say what is true for you
- Be mindful, be present
- Act with commitment

Be Courageous – Model the Way

- Make a difference
- Strive for excellence
- Drive Change

Be Revolutionary – Explore the Possibilities

- Empower and innovate
- Challenge the status quo
- Be groundbreaking

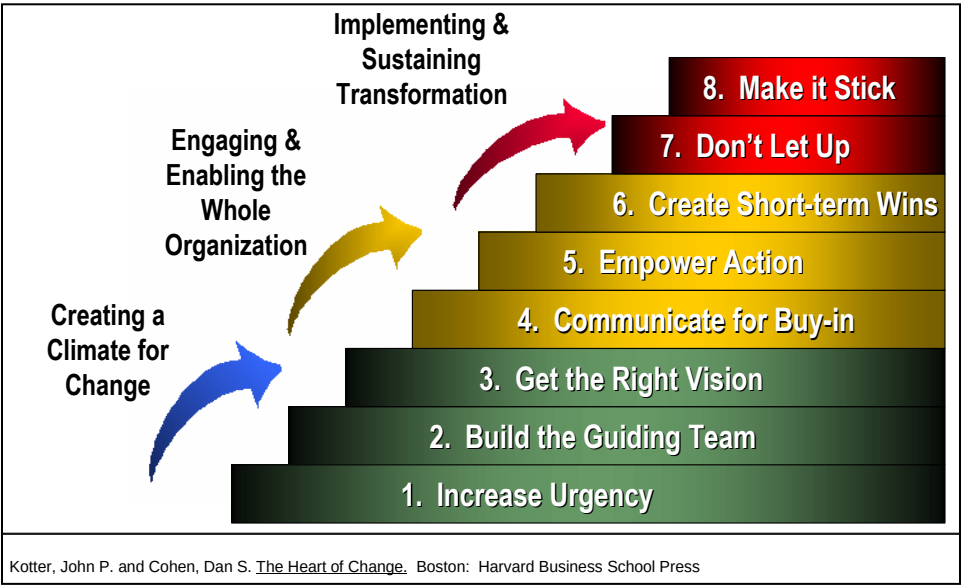


To transform from an old system to a new system, we are ensuring that:

- Quality patient care is delivered to meet local needs (Better Health);
- Care is accessible, well coordinated and sustainable (Better Care); and
- Local health care dollars are spent wisely and appropriately (Better Value).

With this focus, a robust Integrated Health System (Care Connections) Change Management Framework is being developed to drive success, enable the growth of a new culture in the local health system, outline appropriate behaviours to support change and empower change leaders in

the health system to accept the challenge and share accountability for improvement. We are building on the work of John Kotter’s eight step model of change management to embed and sustain transformation in the strategy, structure and culture of a new integrated health system.



Appendix A – Glossary of Terms
Appendix A provides a complete listing of acronyms identified in the North Simcoe Muskoka LHIN Annual Business Plan 2012-13 and is a reference to the reader of this document.

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. That way, we can make measurable improvements in the patient experience, population health and sustainability of the health system. The Care Connections integrated health system 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 priorities reflect the vision of a fully integrated health system for North Simcoe Muskoka by 2020.

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

Integrated Health Service Priority:
<i>Improving access to appropriate care, beginning with the Emergency Room and Alternate Level of Care settings in the community or home.</i>
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, 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 2012/13 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 choose 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 Regional Health Centre (RVH).

ALC days are captured and monitored weekly across all North Simcoe Muskoka hospitals, including Waypoint Centre for Mental Health Care.

Trends in ER/ALC:

- From the summer of 2010 until the first three months of 2011, there has been a decrease of 8.4% in the number of unscheduled visits to the ER across our LHIN.
- By mid 2011, nine out of ten patients in the emergency room were waiting 2.8 hours less in our ERs than the provincial average and a full hour less than they had in the same period in the previous year.
- By mid 2011, 89% of all high acuity patients were treated within 8 hours in the emergency room, which is an improvement of 6.6% from the baseline.
- Patients continue to be satisfied with the care they are receiving in the ER. At the end of 2010, the percentage of patients with an overall positive satisfaction rating in the ER increased to 87%, an improvement of 4% from the baseline.
- At the beginning of 2010/11, 9 out of 10 ALC cases (90th percentile) had a length of stay of 41 days. Data up to the second quarter of 2011/12 shows that length of stay reduced to 39 days representing an improvement of two days.
- Average ALC length of stay decreased by almost 4 days (19 days in the first quarter of 2010/11 to just over 15 days in the second quarter of 2011/12).
- While the overall proportion of ALC days compared to total patient days has remained relatively stable (between 18-20%), the number of ALC days in North Simcoe Muskoka has decreased in four out of the last five fiscal quarters. When comparing the first quarter of 2011/12 with the same period in 2010/11, ALC days decreased from 10,429 days to 8,644 days, representing an improvement of 1,785 days.

Challenges Faced:

- **Rapidly aging population.** In 2011, the North Simcoe Muskoka LHIN had the fifth largest proportion of seniors aged 65+ in the province. The Ministry of Finance projects the proportion of persons aged 75+ to almost double by 2036, representing more than 14% of the total population.
- **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 service 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 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.*** In the first quarter of 2011-12, North Simcoe Muskoka had the third highest rate of unscheduled ER visits in the province, as compared to its counterparts. 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), 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 linked with 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, the North Simcoe Muskoka LHIN continued to perform well in ER wait times with overall performance ranking far above average, in one quarter ranking best in the province. Success 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 improved targets. Over the same period, North Simcoe Muskoka faced ongoing pressures related to ALC performance. As we look forward to 2012/13, we anticipate better success and outcomes as new initiatives targeting ALC move from planning to implementation of core sustainable system change and realignment of resources.

Goal 1: ER Diversion – Funding over the last several years has targeted high-risk ER users to create alternate options for care. 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. The Integrated Regional Falls Program (IRFP) includes services from prevention to specialized geriatric services with the model providing a foundation for much of the provincial planning related to falls prevention. The IRFP, while increasing its client roster by more than twice the anticipated volume, has seen an 86% reduction in ER visits related to falls and an 89% reduction in the number of falls while on IRFP service. Not surprisingly, results of the most recent IRFP client satisfaction survey reflect a highly favourable 97% overall satisfaction rate with the program. Options for primary care have been expanded in North Simcoe Muskoka. In addition to the six Family Health Teams, two new Community Health Centres began operation and two new Nurse Practitioner–Led Clinics were opened. A third Clinic will begin operation in 2012/13. In January 2012, Hospice Huntsville, a five bed facility in Huntsville, was opened to serve patients in the Muskoka region. In January 2012, planning also began for the implementation of a Seniors’ Health Team to serve frail seniors in the Muskoka region.

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 (ED PIP) were significant enablers of this improvement in all five acute care hospitals in the region. Collingwood General and Marine Hospital, Muskoka Algonquin Healthcare, Royal Victoria Regional Health Centre and Georgian Bay General Hospital continue to benefit from completed LEAN process improvements to optimize patient flow. 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. This past year, 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 initiatives were funded in 2010/11 to continue to improve the flow of patients and reduce ALC days. In addition to continued funding for 26 interim Long-Term care beds, funding was provided to complete the North Simcoe Muskoka Palliative Care Resource Team and establish a Seniors’ Health Team in Muskoka. The latter two initiatives are designed to support early discharge and the management of individuals in the community. Significant investment was made to support the implementation of a Home First philosophy. This investment included funding to CCAC, as well as LHIN support in the planning of the CCAC expanded role, including shifting lower needs CCAC clients to the Community Support Sector. Senior Friendly Hospital Strategy planning this past year was fast-tracked by the leadership of a Senior Friendly Hospital Strategy Coordinator. With this support, each hospital is working to implement programs to reduce functional decline in hospitalized seniors in 2012/13. Complex Continuing Care (CCC) continued to be a major focus of North Simcoe Muskoka LHIN work over the past year with a LHIN-wide approach to CCC operations and care well underway under the leadership of a Complex Continuing Care System Coordinator. CCC Committees developed policies and procedures to achieve a standardized approach to care and a bed registry was implemented which has seen a reduction in the volume of ALC and off-service patients in CCC beds. Work was initiated across the care continuum to address the repatriation of patients from acute to long-term care. In 2011, significant leadership was provided provincially and locally in Behaviour Support System planning. With plans well underway, an integrated system of supports for individuals living with behaviours will be implemented in the fourth quarter of 2011/12. Through the re-alignment of existing resources and the addition of new resources individuals and caregivers will receive better care and more individuals will be supported in their home environments. In May 2011, LHIN-wide ALC Bullet Rounds were established. This forum provides an opportunity for front line and leadership representatives from across sectors to have a weekly discussion of ALC current state, discuss trends and issues, explore opportunities for collaboration and collective problem-solving and leverage system capacity. In October 2011, an ALC Project Steering Committee was established within Care Connections. Within two weeks of being created this Committee developed an Action Plan to guide work for the remainder of 2011/12. This Action Plan was built from: discussions held during two 2011 LHIN-led ALC Think Tanks; the work of the previous ER/ALC Steering Committee and the 2011 ALC Working Group; provincial work tied to LHIN Chief Executive Officer (CEO) priorities; and provincial reports like that of Dr. Walker.

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 2012/13, 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	2012-13		2013-14		2014-15	
ER/ALC Strategy						
Revised ER/ALC Strategy to align with 2013-16 IHSP planning	Not yet started	100%				
Implementation of a Performance Monitoring and Reporting Framework to align with the ER/ALC Strategy (including Aging at Home and Urgent Priorities Funding) (65% completed in 2011-12)	In progress	25%	In progress	10%		
Goal 1: Reduce ER Demand						
Implementation of a LHIN-wide Nurse Led Outreach Team into Long-Term Care (65% completed in 2011-12)	In progress	25%	In progress	10%		
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% completed in 2011/12)	In progress	30%	In progress	10%		

Implement a Seniors' Health Team to serve frail seniors in Muskoka (30% completed in 2011-12)	In progress	60%	In progress	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) (15% completed in 2011-12)	In progress	85%				
Goal 2: Build Capacity and Improve Performance within ERs						
Implementation and continued monitoring of the province-wide Pay For Results and ER Performance Improvement Program	In progress	33%	In progress	33%	In progress	33%
Goal 3: Improve Bed Utilization – Allocate Patients to the Appropriate Level of Care for their Conditions						
Implementation and evaluation of the Home First Philosophy in North Simcoe Muskoka (30% completed in 2011-12)	In progress	50%	In progress	20%		
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% completed in 2011-12)	In progress	10%				
Implementation of the province-wide Senior Friendly Hospital Strategy, including local solutions (30% completed in 2011-12)	In progress	30%	In progress	20%	In progress	20%
Reduce CCAC assessment times to 3 days (40% completed in 2011-12)	In progress	50%	In progress	10%		
Implement a standardized ALC high risk assessment tool (30% completed in 2011-12)	In progress	50%	In progress	20%		
Implement integrated discharge planning roles (between hospital and CCAC) across all hospital sites (10% completed in 2011-12)	In progress	70%	In progress	20%		
Implement strategies to remove barriers to access to community resources	In progress	50%	In progress	40%	In progress	10%

Move/shift resources to the community and within hospitals (i.e. assess and restore beds) as appropriate based on system capacity review	In progress	33%	In progress	33%	In progress	33%
Develop and roll-out an ALC messaging campaign to the public, organizations and health service providers (i.e. better to be at home; educate patients and families on discharge options; standardized approach to ALC destination designation; ALC messaging for the ER) (30% completed in 2011-12)	In progress	50%	In progress	10%	In progress	10%
Complete a review of all long-stay ALC patients	Not yet started	100%				
Establish a standardized process across all hospitals for the assessment and management of cases with an ALC length of stay > 30 days and for patients designated ALC within 48hrs of admission	Not yet started	75%	In progress 25%			

How will we measure success?

In 2010/11, outcome measures and targets were set to align with the three-year ER/ALC Strategy. These are based on baseline performance as well as MLPA targets.

Note: Indicators and targets are will be renegotiated as per Ministry Performance Agreement beyond 2012-13 fiscal.

	ER / ALC Indicator	Baseline (2008/09)	Current Performance	Year 1 (2010-11) Target	Year 2 (2011-12) Target	Year 3 (2012-13) Target
GOAL 1: Reduce ER Demand						
1.1	Hospitalized rate for ambulatory care sensitive conditions	343.23	426.75 (10/11 FY)	300	250	200
1.2	Falls-related ER visits/ 100,000 population 65 +	6145.6	6070.3 (2010)	5755.7	5560.8	5365.8

1.3	Unscheduled ER visits/1,000 population	534/ 1,000	523/1,000 (10/11 Q2 - 11/12 Q1)	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 hours	40.0%	48.0% (11/12 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%	88.6% (10/11 Q4)	92.0%	95.0%	95.0%
2.3	Proportion of non-admitted low acuity patients (CTAS IV-V) treated within the LOS target of < 4hrs.	88.0%	89.7% (11/12 Q2)	93.0%	95.0%	95.0%
2.4	Patient Satisfaction – ER Satisfaction	83% Positive / 22% Excellent	87.2% Positive / 28.7% Excellent (10/11 Q4)	85% Positive / 25% Excellent	88% Positive / 30% Excellent	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%	18.58% (11/12 Q1)	15.40%	15.40%	9.50%
3.2	ALC Length of Stay	52 days	39 days (11/12 Q1)	45 days	40 days	30 days
3.3	Median wait time to LTC home placement	160 days	105 days (10/11 Q3 - 11/12 Q2)	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. Established infrastructures like the LHIN Leadership Council, Care Connections Coordinating Councils and Project Committees (including the Emergency Department Network and ALC Steering Project Committee) and weekly North Simcoe Muskoka LHIN-wide Bullet

Rounds, 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. To mitigate these challenges, the LHIN has established a Decision-Making Framework as well as a more robust performance framework to which all funded programs are held to account. These assess value add for the investment and support 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. Technology options and creative solutions to service delivery continue to be explored to promote equity of access and quality care. To support health human resource planning and decision-making, a Health Human Resources (HHR) group has been established through Care Connections. Resource integration and sharing are being explored and implemented across all Care Connections planning tables, where feasible scope of practice and skill sets within the region are also being maximized.
- **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. Organizations involved in such programs are being encouraged to share resources and collaborate to evolve and sustain programming.

What are some of the key enablers that would allow us to achieve our goal?

The North Simcoe Muskoka LHIN has been working diligently over the last several years to build the infrastructure required to support lasting and effective system change. Several key enablers have been put in place to support ER/ALC planning and implementation:

- **Provincial Planning.** Work tied to provincial initiatives is providing a strong foundation for local planning. The North Simcoe Muskoka LHIN is leading the province in **Senior Friendly Hospital** planning with early work focused on reducing functional decline experienced by seniors as a result of hospitalization. This upstream approach strives to optimize and maintain patient abilities thereby reducing the volume being designated ALC. As an early adopter LHIN with the **Behavioural Supports Ontario** project, North Simcoe Muskoka is providing leadership provincially in behaviour support system planning. Through targeted planning and new funding, existing resources are being augmented and new programming is being implemented to better support individuals with behaviours and their caregivers. With behaviours as a key factor in long-stay ALC cases, this initiative will lend to improved patient care and flow. Early provincial and local work related to a '**Home First**' philosophy of care is providing a platform for local messaging and decision-making. By encouraging appropriate patients to go home to await placement, we improve patient flow and enhance patient safety.
- **Care Connections.** Within Care Connections, an infrastructure has been put in place to support planning, decision-making, change implementation and outcome evaluation across the North Simcoe Muskoka LHIN health system. The Emergency Services Project Steering Committee

forms an integral component to the Medicine Coordinating Council, and plans to provide system-level, evidence-based improvement changes to ER operations in coming months. The ALC Project Steering Committee was established in October 2011 with representation from across the continuum of care. This Committee, under the leadership of the North Simcoe Muskoka LHIN, worked quickly to establish an Action Plan to ensure the group's attention and action is focused on moving toward improved ALC outcomes. With the ALC Project Steering Committee, the Home First Committee and the Senior Friendly Hospital Strategy all reporting through to a Coordinating Council focused on In-Home & Community Capacity, there is greater synergy across planning and decision-making.

- **ALC System Lead.** To facilitate planning and action, the North Simcoe Muskoka LHIN has focused the work of one staff member entirely on ALC. With ALC as the biggest challenge facing our region, this was seen as a valuable investment of LHIN funding. This individual is responsible for overseeing the roll-out of the ALC Action Plan, supporting the work of the ALC Project Steering Committee and promoting a LHIN-wide grass-roots approach to ALC reduction.
- **North Simcoe Muskoka LHIN-wide ALC Bullet Rounds.** On a weekly basis, representatives from each hospital, the CCAC and the CSS gather via conference call to discuss ALC current state in North Simcoe Muskoka. This forum provides an opportunity for noting LHIN-wide trends, sharing information and collective problem-solving. This promotes a standardized approach to care and enhances within-sector and cross-sector collaboration.



Access to Integrated Diabetes Care—Chronic Disease Prevention & Management

Integrated Health Service Priority:

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

IHSP Priority Description:

As a support to our Integrated Health Service Plan 2010-13, the Ontario Diabetes Strategy (ODS) and the health of North Simcoe Muskoka residents living with diabetes, the NSM LHIN aims to achieve Better Health, Better Care, Better Value through integrated and collaborative partnerships which:

1. Enhance the delivery of diabetes care in North Simcoe Muskoka; and
2. Enhance the management and quality of diabetes care in the North Simcoe Muskoka.

Chronic Disease Prevention and Management (CDPM) specifically diabetes, was identified as one of the areas of focus as a result of our *Care Connections: Partnering for Healthy Communities* stakeholder engagement. As a result of this planning process, we have entered into our first year of implementation with the development of a CDPM Project Steering Committee (PSC). The overarching area of focus will continue:

- The advancement of a LHIN-wide model for chronic disease prevention and management which aligns with LHIN and provincial initiatives and is focused on diabetes.

Key Deliverables and Milestones achieved in 2011-12:

- Implementation of NSM LHIN diabetes indicators, borrowing from the work of Baseline Diabetes Dataset Initiative (BDDI), we included indicators which addresses best practice guideline targets for HbA1C (blood test), Low-density Lipids Data (LDL) Initiative and Retinal Eye Exams in our LHIN indicators. The intent was to also prepare our region for the impending Diabetes Registry.
- Strategic alignment and collaboration with the Diabetes Regional Coordination Centre (DRCC) will continue to ensure we are achieving our overall goal of a LHIN-wide model for CDPM with a focus on diabetes.
- Diabetes Self-Management: The South Georgian Bay Community Health Centre (SGBCHC) was able to implement a diabetes self-management program with the funding provided through the Ontario Diabetes Strategy and surpass deliverables. In all cases, SGBCHC was able to surpass or achieve the targets.

Self Management and Education January 2011-June 2011

	A. Individuals Living with or at Risk of Diabetes			B. Health Service Providers			
	#of individuals with or at risk who received self management education/training	# of people trained as peer leaders	# of surveys	# of HSPs who received Self-Management Training	# of HSPs who received mentorship	# of people trained to deliver self-management	# of surveys distributed to participants
Target	25	8	n/a	40	20	2	n/a
Actual	25	14	n/a	48	20	12	n/a

- The CDPM PSC has developed the Terms of Reference for the committee, the Project Charter and is now developing the work plan for the remainder of 2011-12 and into 2012-13. The CDPM PSC will complete a CDPM inventory, implement Care Pathways and consider information technology (IT) in the delivery of Care Pathways.
- A Diabetes Education Day was held in Barrie on November 18, 2011 and attended by over 120 Health Service Providers. The day focused on new and innovative methods for managing diabetes including Bariatric Surgery and Managing Metabolic Syndrome for co-morbidity (mental health and diabetes) clients at Waypoint Centre for Mental Health Care.

Current Status: Achievement – Demonstrating Investment into Action

Provider and Type of Health Service Provider

Provider	Type
1. Collingwood General Marine (CGMH)	Hospital Diabetes Education Centre (DEC)
2. Muskoka Algonquin Healthcare Huntsville (MAHC-H)	Hospital Diabetes Education Centre
3. Orillia Soldiers' Memorial Hospital (OSMH)	Hospital Diabetes Education Centre
4. Royal Victoria Regional Health Centre (RVH)	Hospital Diabetes Education Centre
5. Barrie (BCHC)	Community Health Centre, Diabetes Management Centre
6. South Georgian Bay (SGBCHC)	Community Health Centre
7. Chigamik (CCHC)	Community Health Centre
8. Algonquin (AFHT)	Family Health Team
9. Bracebridge (BFHT)	Family Health Team
10. Barrie & Community (BCFHT)	Family Health Team
11. Couchiching (CFHT)	Family Health Team
12. Cottage Country (CCFHT)	Family Health Team
13. Georgian Bay (GBFHT)	Family Health Team
14. North Simcoe (NSFHT)	Family Health Team
15. North Simcoe Regional Diabetes Program (NSRDP)	Other

*NOTE: Data Provided by the NSM LHIN DRCC as of March 2011.

Scope of Services Currently Provided

Legend: G = Services delivered in a group setting and I = Services delivered on an individual basis

T1 = Type 1 Diabetes and T2 = Type 2 Diabetes

Clients Served By The Program	CGMH DEC	MAHC DEC	OSMH DEC	RVH DEC	BCHC	SGBCHC	AFHT	BCFHT	CFHT	CCFHT	GBFHT	NSFHT	NSRDP
People at high risk for T2 Diabetes			G							GI	I		
Prediabetics	GI	G	G	I	GI	GI	G		GI	GI	I		
T2 diabetes on lifestyle management only	GI	GI	G	I	GI	GI		I	GI	GI	GI		I
T2 diabetes on oral medication	I	GI	GI	I	GI	GI		I	GI	GI	GI	I	I
T2 diabetes on insulin and/or oral medication	I	GI	GI	I	GI	GI		I	GI	GI	GI	GI	I
T2 diabetes insulin initiation	I	GI	I	I	I	GI		I	I	GI	I	I	I
T2 diabetes on insulin pump therapy			GI	I	I	GI		I		GI			
T1 diabetes on insulin injections	I	GI	GI	I	I	GI		I	I	GI		I	I
T1 diabetes on insulin pump therapy		GI	GI	I	I	GI		I		GI			
Gestational diabetes	I	I	I	I	I	GI				GI		I	I
T1 with pregnancy		I	I	I	I	GI				GI			
T2 with pregnancy	I	I	I	I	I	GI				GI			

*NOTE: Data provided by NSM LHIN DRCC as of March 2011

Key Issues (As shared by NSM LHIN DRCC):

1. Clients which do not have a primary care physician;
2. Recruitment of new staff;
3. High turnover/staff retention;
4. Replacing leaves (maternity/sick);
5. Continuing education;
6. Care coordination with other health service providers;
7. Communication with other health service providers (e.g. family physician);
8. Access to service; and
9. Need for social work, need for printing materials in other languages, financial support / entitlements for patients.

Key Successes:

- The implementation of a Chronic Disease Prevention and Management Project Steering Committee. Between Jan. 2012-Mar. 2013 the committee will develop CDPM Care Pathways and a method of system navigation for HSPs and patients/clients;

- The Services, Primary Care, and Pharmacy Inventories of Diabetes programs and services completed by the Diabetes Regional Coordination Centre;
- The hiring of a 0.5 social worker in Midland;
- Diabetes Education Day hosted by the DRCC which focused on new and innovative strategies to manage and prevent diabetes including metabolic syndrome for those with Mental Health issues and Bariatric Surgery;
- Increase in certified pump trainers; and
- Surpassing of targets for self-management training.

**BDDI SubLHIN Analysis of Diabetes Testing Rates
as of July 2011 (Hospital and Community Labs by SubLHIN)**

All Persons With Diabetes as Percentage

Geographic Location	All 3 Tests done	A1C within past 6 months	LDL-C within past year	Retinal Eye exam within past 2 years
Collingwood and Area	38	56	67.7	69.4
Barrie and Area	41.6	58.9	71.6	67.5
Orillia and Area	43.8	63.7	69.3	71.5
Midland/Penetanguishene & Area	25.8	41.4	49.6	70.3
Muskoka and Area	41.5	61.4	61.4	74.9
NSM Totals	39.5	57.5	66.5	69.8
Provincial Totals	39.6	56.5	69.1	67.6

- According to Health Care Connects Monthly Data Report for the North Simcoe Muskoka LHIN from February 12, 2009 to October 31, 2011 the number of Registered, Complex, Vulnerable Patients was 804 of which 604 were Referred, Complex, Vulnerable Patients meaning 75% of registered, complex, vulnerable patients were referred.

Goal(s):

The NSM LHIN continues to enhance our strategic partnerships in support of the activities which align with our four focused goals:

1. Improving the delivery of diabetes care in NSM;
2. Improving the management and quality of diabetes care in NSM;
3. The advancement of a LHIN-wide model for chronic disease prevention and management (CDPM), and
4. The advancement of NSM LHIN and provincial initiatives, with a focus on diabetes.

Action Plans						
	2012/13		2013/14		2014/15	
	Status	%	Status	%	Status	%
GOAL 1: Enhance the service delivery of diabetes care in the NSM						
Leverage via DRCC and CDPM Project Steering Committee (100% completed in 2011-12)						
Establish local diabetes networks/ collaboratives in each of the 5	In Progress	50%	In Progress	25%		

geographic areas (25% completed in 2011-12)						
All NSM CDPM providers (emphasis on diabetes-related programs and services) profiled on Ontario211 (75% completed in 2011-12)	In Progress	25%	In Progress			
Improve the design of the delivery system for diabetes care through an integrated framework to enhance self-management practices/supports across the continuum (inclusive of Francophone and Aboriginal population) (35% completed in 2011-12)	In Progress	35%	In Progress	30%		
Build local Health Human Resource (HHR) capacity and increase access to primary care, diabetes education and services in Wasaga Beach and Midland/Penetanguishene through two new CHCs (including Francophone and Aboriginal populations and HHR)	Complete	100%				
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 DRCC Steering Committee and working groups and have aligned work plans to support deliverables in 2012 and beyond (75% completed in 2011-12)	In Progress	25%				
Position for roll-out and implementation for diabetes registry in NSM LHIN (85% completed in 2011-12)	On hold					
Performance monitoring of a diabetes care indicator in service accountability agreements/system performance with community HSPs	As per Year 2 MSAA		As per Yr 3 MSAA		Renew MSAA	
Reduced emergency department visits and hospitalizations by individuals with diabetes and diabetes related complications	In Progress		In Progress	25%	In Progress	75%
Goal 3: Advance a LHIN-wide model for CDPM						
Develop a coordinating/advisory body that will drive the CDPM agenda forward (100% completed in 2011-12)	Complete					
Advance the concepts and practice of personal skills and self-management supports beyond diabetes	In Progress	25%	In Progress	25%		

(50% completed in 2011-12)						
Design and deploy an integrated screening program, screening priorities and life stages for screening initiatives	Not yet started			25%		75%
Advance the model concepts of the Ontario CDPM Framework (20% completed in 2011-12)	In progress	30%	In Progress	50%		
Goal 4: Advance NSM LHIN and provincial initiatives, with a focus on diabetes						
Support the integration and service capacity of 3 awarded Nurse Practitioner (NP) Led Clinics (50% completed in 2011-12)	In progress	50%				
Support the roll out of the current ODS (100% completed in 2011-12)	Complete					
Identification and enrolment of individual candidates for self-management support programs (30% completed in 2011-12)	In progress	70%				
Develop a health and wellness strategy focused on risk-reduction	In Progress	25%	In Progress	50%	In Progress	25%
Support the French Language Health Planning Entity - FLHPE#4 in the delivery of services in French	In progress	33%		33%		33%
Support the First Nations and Métis, Inuit (FNMI) Health diabetes agenda in NSM LHIN	In progress	25%		50%		25%
How will we measure success?						
• Increase in A1C and LDL-C blood testing in order to surpass the Provincial Averages. • Development and implementation of a System Navigation Tool and Care Pathway for CDPM. • Development and implementation of System wide performance measures.						
What are the risks/barriers to successful implementation?						
• Training and resources.						
What are some of the key enablers that would allow us to achieve our goal?						
• IT infrastructure and electronic medical record (EMR) implementation in all acute and primary care • Settings • System navigation using Ontario211. • Self-management implementation and use across the health care continuum.						

Integrated Health System – Care Connections – Partnering for Healthy Communities

Integrated Health Service Priority:

Designing an Integrated Future State of the Health System in North Simcoe Muskoka; (Care Connections – Partnering for Healthy Communities)('CC Plan')

Note: As per the 2010-13 IHSP, three strategic priorities were outlined. With the integrated health system plan ('CC Plan') which was designed in 2010/11 and began implementation in 2011/12 ER/ALC and Diabetes have now been fully integrated into the system-wide transformation plan.

IHSP Priority Description:

Care Connections Vision: *Healthy people. Excellent care. One system.*

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.

Background

The Integrated Health System Design (IHSD), branded as *Care Connections – Partnering for Healthy Communities*, is a 10-year strategic plan that outlines steps to be taken to collectively realize this vision.

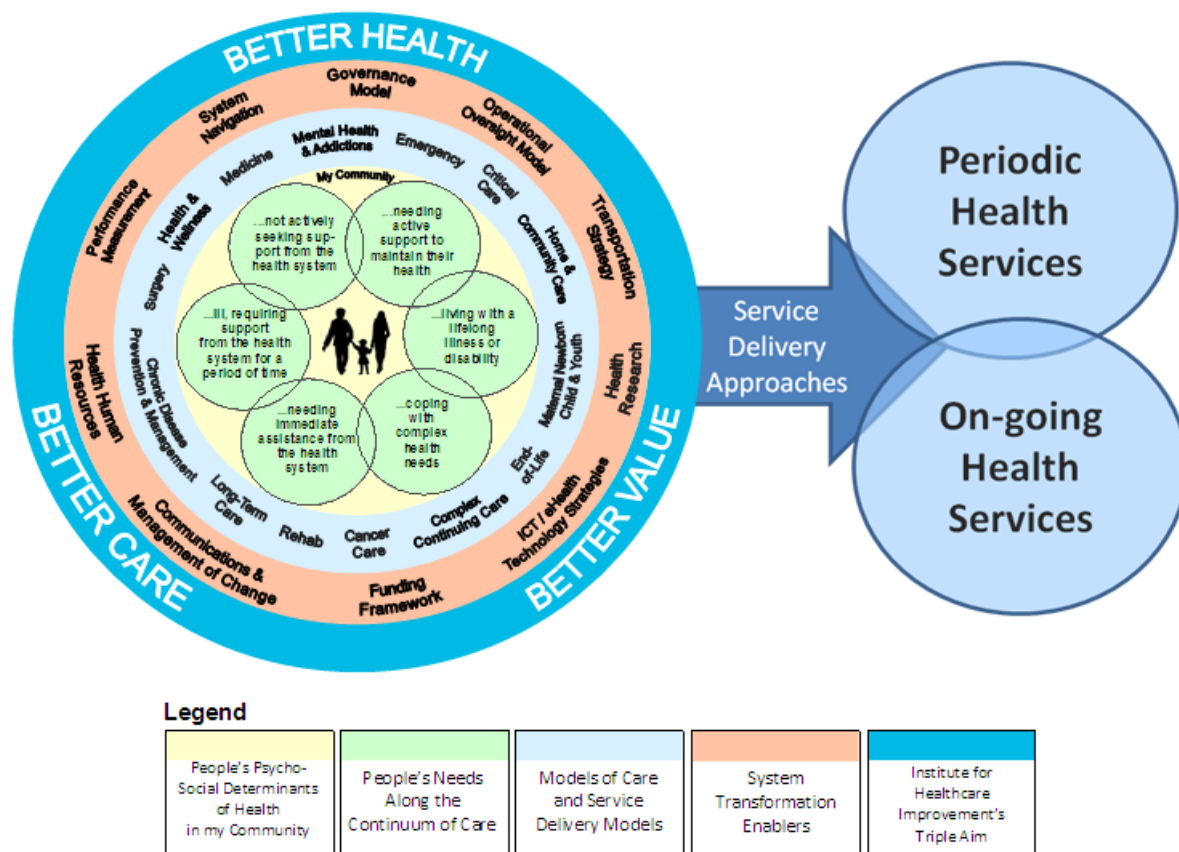
Over 350 persons in a period of 14 months (2010/11) contributed in excess of 20,000 hours of their time, engaged in facilitated working sessions using “best available” data/information, leading practices and expertise within their particular area of care in Ontario and other jurisdictions. Informed by the residents of North Simcoe Muskoka and the results of nine working groups of front-line stakeholders, the ‘CC plan’ includes models of care and service delivery approaches with over 500 associated short, medium and long-term recommendations, and a transformation model to guide implementation. These initiatives 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 value for money across several sectors of care; *better health, better care and better value*. The ‘CC Plan’ provides for 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 ‘CC Plan’ provides for a supportive environment to help create a healthier population, able to maintain better health, through all stages of life.

While these collective initiatives take place over a 10 year period (2010 – 2020), the NSM LHIN Board approved implementation planning in twelve ‘areas of focus’ in February 2011. Stakeholders actively involved include 77 LHIN funded health service providers (HSPs), more than 70 non-LHIN funded organizations representing all sectors across the continuum of care and the public representing ‘persons with lived experience’. Several organizations whose primary mandate relates to other determinants of health are included in order that a fully integrated health system design can be achieved.

The Care Connections Plan sets out:

- How individuals and their support systems (partners, families, communities in which they live) 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 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); and
- 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. See the *System Transformational Model*.

System Transformation Model



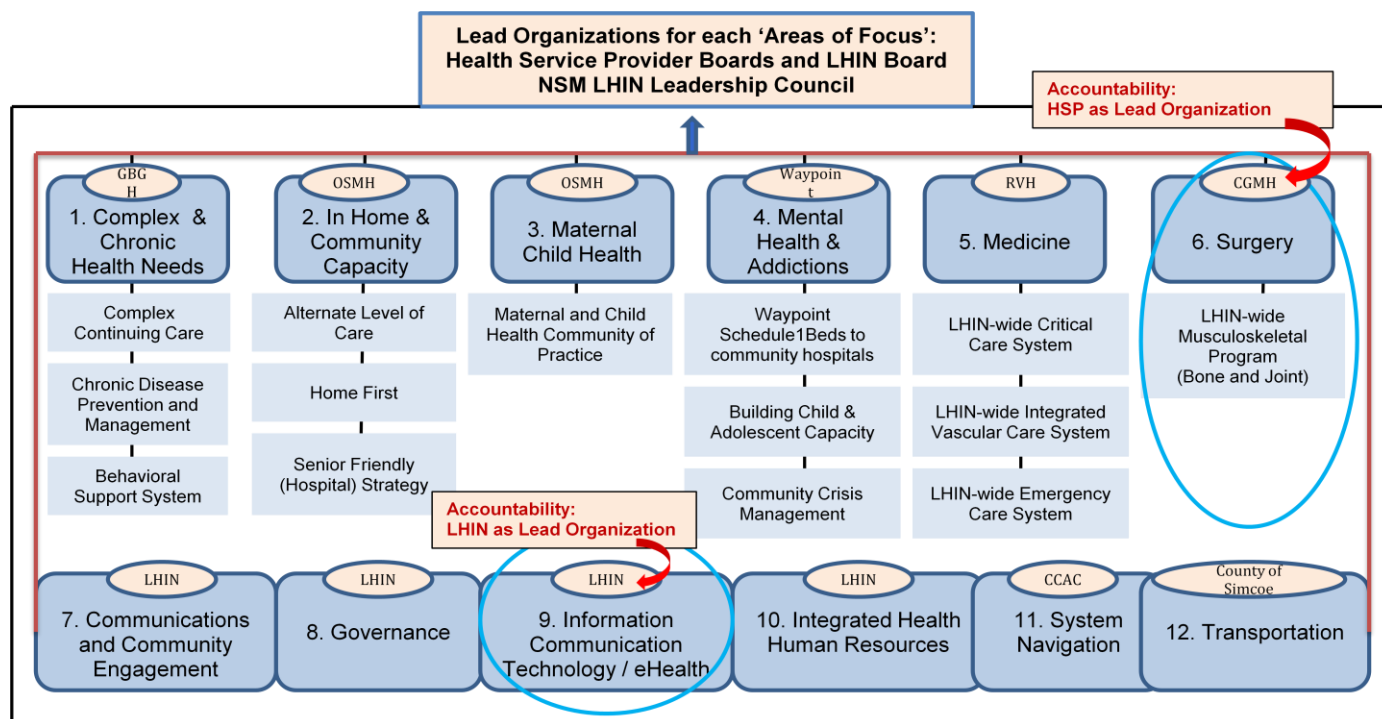
An Information Communication Technology/eHealth (ICT) 3-year strategy has been created for the development of an ICT infrastructure and business solutions required in each of the 'areas of focus'.

The 10-year Care Connections Plan is on the NSM LHIN website. [Care Connections Report - February 28, 2011](#)

Current Status

In year 1 of implementation planning (Q4 2010/11- end of Q4 2011/12), structures for twelve identified “areas of focus” were created and deployed utilizing, where possible, existing resources in the system.

Implementation Structure (Years 1- 3)



Oversight Structures

Led by a Steering Committee of Senior Administrative and Clinical Executives, the NSM LHIN Leadership Council, ‘the CC Plan’ has structures and processes in place to make key decisions, lead change, ensure accountability for delivery of a LHIN-wide system for preventative and supportive care, monitor progress and evaluate outcomes. Given the relationships now established and mechanisms in place to support collaboration and decision making, implementation of the ‘CC Plan’ allows for course correction, when necessary, to meet needs of the population and changing environments.

Project Management

The twelve ‘areas of focus’ are managed by a **Lead Organization; which involves six local HSP Boards and the LHIN Board**, accountable for the delivery of multiple projects (total >40 projects and sub-projects) within their specific portfolio and a **Coordinating Council** that oversees the work of all goals pertaining to projects within their mandate.

Coordinating Councils are comprised of representatives of the **Project Steering Committees** and key informants and advisors. The Project Steering Committees include representatives of front-line clinical and administrative services within and beyond health care. All members were involved in the design phase of the ‘CC Plan’.

A **Care Connections Operations Committee** brings together the Chairs of each of the 12 Coordinating Councils, NSM LHIN Integrated Health System Design Director and Integration Manager, to coordinate system transformation work. Alignment with the **Ontario Public Service (OPS) Project Management**

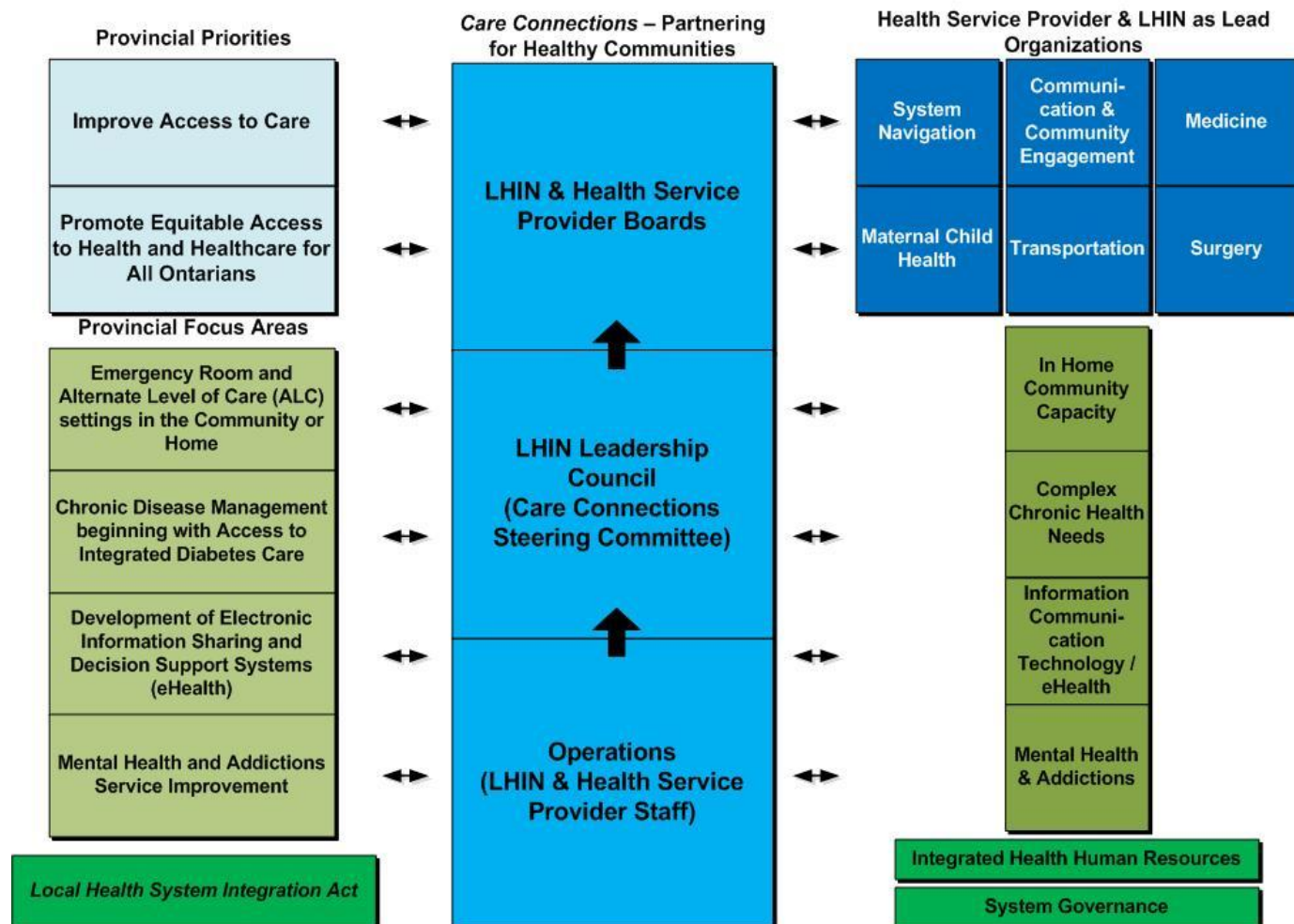
Framework, 2007 provides clear direction for all 12 Coordinating Councils. Tools necessary to support the infrastructure; project charters, terms of reference, risk assessment, evaluation of results, license and training of Eclipse, etc. are utilized by each team. The NSM LHIN has deployed all staff to support ongoing work in these 12 key 'areas of focus'. From the general public, 'persons with lived experience' have joined all Project Steering Committees as voting members.

Shared Accountability

To achieve the vision and sustain an integrated health system in North Simcoe Muskoka, the health system resources will begin to shift and along with that will be the expectation for the accountability to change. The seven Lead Organizations have demonstrated a commitment to change and provider Boards have currently signed accountability agreements and passed board motions to implement and share accountability for the results of these areas of focus. The Lead Organizations are working together as a system and are accountable for the deliverables within their specific area of focus. Boards expect significant change and are working with the LHIN Board to develop new mechanisms appropriate to govern an integrated health system.



HEALTH SYSTEM SHARED ACCOUNTABILITY IN NORTH SIMCOE MUSKOKA



Goal (s)

*The vision of the North Simcoe Muskoka LHIN is **Healthy People. Excellent Care. One System** in which an environment will be created to support the effective transformation to an integrated health system.*

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:

- Ontario's Action Plan to Transform Health Care, Jan. 30, 2012;
- Excellent Care for All Act, June 2011;
- Rural and Northern Care Framework, Ontario Hospital Association (OHA)/MOHLTC, Dec. 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 Agency, Healthy Communities Project, 2011;
- Home First Strategy, 2011;
- Seniors' Friendly Hospital Strategy, 2011;
- Integrated Falls Prevention Strategy, 2011;
- Behavioral Support Ontario Strategy, 2011;
- Ontario Integrated Vascular Strategy, Jan 2012;
- Ontario Bone and Joint Health Network; Orthopedics Expert Panel, 2008;

- Ontario Behavioural Supports Framework, October 2010;
- Provincial Council for Maternal & Child Health Recommendations, 2011;
- Complex Continuing Care and Rehabilitation Provincial Leadership Council, 2010; and
- Caring for Our Aging Population & Addressing Alternate Level of Care (Walker Report), June 2011.

Action Plans/Interventions

Description	2012/13	2013/14	2014/15
Phase 1: Implementation Planning:			
1.1 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 twelve "areas of focus" in first 3 years of 10 year plan (2010/11 – 2013/14). <i>(Note: 100% completed in 2010/11. In 2013/14 will determine next "areas of focus" for completion of 10 year Plan).</i>		100%	
1.2 Align NSM LHIN staff and other resources to support each of the organizational oversight bodies. <i>(Note: 100% completed in 2010/11. In 2013/14 will determine appropriate resources required to support next "areas of focus" for completion of 10 year Plan).</i>		100%	
1.3 In collaboration with the Operational Oversight structures, align Care Connection implementation plans with provincial priorities, as noted above. <i>(Note: 100% completed in 2010/11 and 11/12 and refreshed as new provincial priorities set).</i>		100%	
Phase 2: LHIN-wide Program/Service Monitoring: (Note: 25% of work in 2.1, 2.2 and 2.3 completed in 2011/12)			
2.1 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'.	50%	25%	
2.2 Establish agreement on benchmarks and targets related to each deliverable in each of the plans	50%	25%	
2.3 Monitor and report progress via balanced scorecard and quarterly reports through the LHIN Leadership Council to Local Leadership Councils (LLCs) and integrated health system partners.	50%	25%	
Phase 3: Funding of LHIN HSPs and new initiatives / provincial priorities:			
3.1 Align portion of total funding (\$750M) distributed across LHIN-funded organizations to support integration initiatives (Note: \$250K in 2010/11 and \$250K in 2011/12)	75%	25%	
3.2 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.	20%	60%	20%

Phase 4: Integration of Programs/Services:			
4.1 Support, monitor effectiveness, and evaluate outcomes related to all integrations occurring within the areas of focus through: (Note: 25% completed in 2010/11)	25%	50%	
4.1.1 LHIN Board agreements on integrations, where appropriate, (Note: 5% completed in 2011/12)	15%	60%	20%
4.1.2 LHIN review of annual quality improvement plans as they relate to outcomes on better health, better care, and better value. (Note: 100% reviewed in 2011/12)	Review 100% of HSPs QIPs each year		
4.1.3. LHIN reporting on integration initiatives through Stocktake or other means required by the MOHLTC. (Note: 100% completed in 2011/12)	Report 100% as per schedule for Stocktake and ABP		
Years 4 – 10 Planning and Implementation			
Review, monitor and evaluate success of Years 1-3 initiatives to then base planning and implementation for Years 4-10.	20%	30%	50%

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 in the following roles:

NSM LHIN in Collaboration with its Health System Partners:

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

LHIN Board and Health Service Provider Boards:

- Facilitate 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 accountabilities in an integrated health system
- Inform all parties on local planning area perspectives as project implementation related to Care Connections takes place
- Provide direction for Board leadership to balance organization-specific accountabilities and system-wide initiatives (e.g. Memorandums of Understanding)
- Provide clear indication of support and direction through accountability agreements with collaborating organizations to create shared accountabilities (Hospital Service Accountability Agreements, Multi-service Sector Accountability Agreements, etc.)
- Continue progressive discussions and develop 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:

- Share accountability and provide leadership with responsibility for implementation, coordination, capacity building, performance measurement and evaluation
- Provide direction for initiatives as they align to the overall *Care Connections* implementation plan
- Coordinate local geographic area and LHIN-wide priorities to align to provincial/national mandates
- Foster a culture and mechanism for knowledge and information-sharing and exchange among providers and individuals
- Evaluate and monitor progress of LHIN-wide programs/services at a system and local level

Health Service Providers, Health System Partners and Health Care Professionals:

- Seek opportunities to integrate the health system in alignment with the implementation plan
- Transform leadership relationships to facilitate and oversee system-wide change
- Foster and celebrate success in all NSM organizations
- Support each other to realize an improved system-wide integrated Health Human Resource Plan

How we will measure success?

NSM LHIN and partners are champions for quality improvement in the health system. Led by the NSM LHIN Health System Performance Team, managers from across the system are building a Performance Framework that is focused on measuring success in achieving the organization's vision of **Healthy People. Excellent Care. One System.**

To this end, a concerted effort has been made to align the performance framework with:

- The Institute for Health Improvement's Triple AIM approach
- NSM LHIN's Balanced Scorecard
- Health Quality Ontario's Attributes of high-Performing health systems (aka 9 dimensions of quality)

NSM LHIN's performance framework leverages existing data and metrics while providing analytical support to allow cascaded performance reporting at multiple levels of the Care Connections Structure (e.g. Leadership Council, Coordinating Councils, Project Steering Committees, etc.) at different levels of the system, and across different types of providers. The foundation of the framework involves all improvement efforts being initiated by addressing three questions asked by API's Model for Improvement: **What are we trying to accomplish?; How will we know that a change is an improvement?; and What Changes can we make that will result in the improvements that we seek?.**

This approach guides the monitoring and evaluation activities while enabling the development of specific outcome and process measures for achieving high quality local health system performance. In addition to indicators specific to their 'area of focus', Project Steering Committees and Coordinating Councils are developing system-wide metrics to address areas reported by HQO on an annual basis. (see Table 1). Ongoing efforts will focus on providing the system partners and groups within the Care Connections structure with baseline performance information as well as targets for achievement over multiple years.

Table 1. North Simcoe Muskoka LHIN compared to Provincial Average, HQO Quality Monitor Report, 2011	
Superior results, no room to improve	None
Better than average results, still room to improve	Access to primary care (% of population without a family doctor similar to average, but very low % of population)
Average results, still room to improve	• ALC hospital bed days • Access to primary care (% of population without a family doctor similar to average, but very low % of population who can get timely appointment with family doctor) • Waits for CT scans, general surgery & cancer surgery • Home care waits • Avoidable hospitalizations (most indicators at provincial average; readmissions higher for asthma, GI bleed) • Chronic disease management (diabetes complications, AMI survival) • Use of right drugs for hospital patients with AMI, CHF • C-section rates • LTC safety and effectiveness (average for most indicators; higher (worse) rate of new starts of benzodiazepines among residents) • Home care safety and effectiveness (average results for most indicators; worse results for decline in cognitive function and unintended weight loss) • Average supply of family doctors and nurses; relatively low supply of specialists; relatively high supply of registered practical nurses • Preventive health screening (lower physical inactivity but higher smoking in pregnancy)
Worse than average results, major room to improve	• Longer waits for a LTC bed • Longer waits for hip and knee replacement • Higher rate of avoidable ER visits by LTC residents, especially for low acuity visits

Appendix B – Care Connections

Appendix B outlines each of the Care Connections areas of focus and their corresponding projects, including the purpose, goals, deliverables and action plans of the 12 Coordinating Councils and Project Steering Committees. This represents deliverables scheduled to the end of fiscal 2013/14. Included in the 2013/14 timeframe are evaluation of years 1-3 and implementation planning for the remaining years of the 10-year 'CC Plan'.

LHIN Operations and Staffing

LHIN Operations Sub-Category (\$)	2011/12 Forecast	2012/13 Allocation	2013/14 Planned Expenses	2014/15 Planned Expenses
Salaries and Wages	2,120,450	2,500,329	2,500,329	2,500,329
Employee Benefits				
HOOPP	208,464	225,030	225,030	225,030
Other Benefits	218,663	325,043	325,043	325,043
Total Employee Benefits	427,127	550,073	550,073	550,073
Transportation and Communication				
Staff Travel	49,816	40,000	40,000	40,000
Governance Travel	22,778	23,000	23,000	23,000
Communications	45,970	40,000	40,000	40,000
Others	27,483	10,000	10,000	10,000
Total Transportation and Communication	146,047	113,000	113,000	113,000
Services				
Accommodation	278,230	195,905	195,905	195,905
Advertising	7,696	5,000	5,000	5,000
Consulting Fees	200,000	20,000	20,000	20,000
Equipment Rentals	7,372	8,000	8,000	8,000
Governance Per Diems	114,425	112,800	112,800	112,800
LSSO / LHINC Shared Costs	573,546	389,500	389,500	389,500
Other Meeting Expenses	78,335	65,000	65,000	65,000
Other Governance Costs	21,543	15,000	15,000	15,000
Printing & Translation	35,247	25,000	25,000	25,000
Staff Development	66,731	63,263	63,263	63,263
Other Services	162,551	27,785	27,785	27,785
Total Services	1,545,676	927,253	927,253	927,253
Supplies and Equipment				
IT Equipment	46,032	21,000	21,000	21,000
Office Supplies & Purchased Equipment	84,823	40,000	40,000	40,000
Total Supplies and Equipment	130,855	61,000	61,000	61,000
LHIN Operations: Total Planned Expense	4,370,155	4,151,655	4,151,655	4,151,655
Annual Funding Target	4,370,155	4,151,655	4,151,655	4,151,655
Variance	0	0	0	0

LHIN Staffing Plan (Full-Time Equivalents)

Position Title	2012/13 Actuals as of Mar. 31/12 FTEs	2013/14 Forecast FTEs	2014/15 Forecast FTEs	2015/16 Forecast FTEs
LHIN Operations				
Administrative Assistant	2	2	2	2
Advisor	2	2	2	2
Analyst	1	1	1	1
Chief Executive Officer	1	1	1	1
Chief Operating Officer	1	1	1	1
Communications Coordinator	1	1	1	1
Controller	1	0.5	0.5	0.5
Director	3	3	3	3
Executive Assistant	3	3	3	3
Executive Coordinator	1	1	1	1
Manager, Corporate Services	0	0	0	0
Office Assistant	0	0	0	0
Planning Coordinator	1	1	1	1
Program Assistant	1	1	1	1
Quality Improvement Coach	1	1	1	1
Senior Advisor	3	3	3	3
Senior Analyst	0	0	0	0
Senior Director	0	0	0	0
Senior Manager	3	3	3	3
Senior Planner	0	0	0	0
Sub-total FTEs	25	24.5	24.5	24.5
LHIN Initiatives				
eHealth, Lead / Chief Information Officer	0	0.2	0.2	0.2
eHealth, Sr. Project Manager	1	1	1	1
eHealth, Project Manager	1	1	1	1
eHealth, Administrative Assistant	1	1	1	1
ER/ALC, Performance Lead	1	1	1	1
French Language Services, Coordinator	1	1	1	1
Sub-total FTEs	5	5.2	5.2	5.2
Total FTEs	30	29.7	29.7	29.7

Communications Plan

Part 1 – Communicating the Annual Business Plan

Purpose of Annual Business Plan

The Annual Business Plan is one of three guiding documents that are critical to the work of the North Simcoe Muskoka LHIN. The other two documents are the Integrated Health Service Plan (IHSP) 2010-13, ***Working Together to Achieve Better Health, Better Care, Better Value*** and the ***Care Connections – Partnering for Healthy Communities*** report.

The IHSP defines the priorities to be undertaken from 2010 to 2013 that will move us closer to an integrated health system of care. The ***Care Connections*** report details the need for a fully integrated, person-centred health system of care and it lays out the foundational strategies that will lead us to this vision. The Annual Business Plan demonstrates progress made toward reaching the IHSP goals and objectives and 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 our communities.

Why do we do an ABP?

Under the Local Health System Integration Act (LHSIA) 2006, and the Ministry-LHIN Performance Agreement (MLPA), LHINs are required to publish their Annual Business Plan 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 our 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 our 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 care system. The ABP also provides funding LHIN funding requirements for the next three years with particular focus on the 2012-13 fiscal year.

Target Audiences

The North Simcoe Muskoka LHIN deals with many stakeholder audiences, each with its own, and often differing, understanding of the health system and the role of the LHIN in funding, planning and integrating the system. Stakeholders can be categorized in several categories and sub-categories:

- Ministry of Health and Long-Term Care
- Internal to the North Simcoe Muskoka LHIN
 - North Simcoe Muskoka LHIN Board of Directors
 - North Simcoe Muskoka LHIN Senior Leadership Team
 - North Simcoe Muskoka LHIN Staff
- Care Connections Advisory
 - North Simcoe Muskoka LHIN Leadership Council
- Health System
 - Hospitals
 - North Simcoe Muskoka CCAC
 - Long-Term Care Homes

- Community Health Centres
 - Community Service Agencies
 - Mental Health and Addictions Agencies
 - FLHPE – French Language Health Planning Entity #4
 - Aboriginal Health Circle
 - Public Health
 - Emergency Medical Services
 - Primary Care
 - Government – Municipal, District and County
- External Stakeholders
 - Members of Provincial Parliament (MPPs)
 - General Public inclusive of diverse populations (i.e. Aboriginal and Francophone communities)
 - Media

Communications Strategy

The Annual Business Plan describes many key initiatives to advance the priorities of the IHSP and each of these has its own communication strategy. In addition, the North Simcoe Muskoka LHIN has an overall strategic communications plan that outlines the various tactics used to communicate with stakeholder groups.

This section of the ABP therefore will focus on the strategy to build awareness and understanding of the ABP among all stakeholder groups.

Stakeholder	Timing	Tactic	Details
DRAFT ABP			
Ministry of Health and Long-Term Care	January 31, 2012	Electronic Submission	Submission of draft ABP to MOHLTC
Final ABP			
North Simcoe Muskoka LHIN Board of Directors	May 28, 2012	Open Board meeting	A summary presentation and the full text of the final ABP
North Simcoe Muskoka LHIN Leadership Council	Upon Ministry approval	Meeting	Summary presentation plus full text of ABP
Health System MPPs	Upon Ministry approval	Email notification	An email, from the LHIN CEO, including attachment of full text ABP, in advance of public posting
Media/General Public	Upon Ministry approval	Posting on LHIN Website with web alert	Simultaneous posting by all LHINs of MLPA and ABP

Part 2 – Communication Plan for Provincial LHIN Priorities

While the LHIN system enables health planning to address local issues, there are a number of common initiatives and platforms that can best be addressed in a coordinated and consistent fashion. To support these activities, and to enhance the awareness of the LHIN role with key stakeholders, LHINs, with the support of the Ministry of Health and Long-Term Care, have worked together to ensure a consistent overarching communication plan and branding approach to support the following key provincial priorities:

1. **Home First** - Home First is a philosophy and common understanding that when a person enters a hospital with an acute episode, every effort is made to ensure adequate resources are in place to support the person to ultimately go home on discharge, if appropriate.
2. **Senior Friendly Hospitals** - Research shows that seniors are more vulnerable to adverse events and complications the longer they stay in the hospital. They have a two-fold risk of adverse events (e.g., falls, pressure ulcers, surgical complications and hospital acquired delirium). One-third of frail seniors lose independent function as a result of hospital practices. These risks increase the likelihood that seniors will not be able to be discharged and will become ALC.

The Senior Friendly Hospital Strategy strives to foster hospital environments that respond to seniors' physical and mental health needs, promote good health (e.g., nutrition, activation), are safe (e.g., prevent drug interactions, infections, falls), and involve seniors, their families and caregivers fully in the client's care. After their acute care is completed, seniors regain their health so that they can transition to the next level of care – post-acute, home, community or long-term care.

3. **Provincial Falls Prevention Strategy** - In September 2010, falls prevention was identified as a top priority by the Ministry of Health and Long-Term Care (MOHLTC). In response, the *Integrated Provincial Falls Prevention Project* was initiated as a Local Health Integration Network (LHIN)-priority project, in partnership with Ontario's Public Health Units.

The *Integrated Provincial Falls Prevention Framework & Toolkit* was developed to improve quality of life for Ontario seniors aged 65 years and over and to lessen the impact of falls on the health system by reducing the number and impact of falls.

4. **Resource Matching and Referral** - Some of the most significant quality of care issues occur in transition points in the health system as patients/clients move from one provider to the next. In the absence of an electronic system to support patient referrals, health service providers frequently base referrals on incomplete knowledge of available services and significant time and resources are spent on the administrative burden of completing and faxing multiple forms.

To address this issue, Ontario's LHINs are working together towards an electronic referral information solution based on a system first introduced in the Toronto Central LHIN. A Resource Matching & Referral (RM&R) system expedites referrals and matches individuals to the earliest available services that best meet their needs, improving quality of care and the experience of individuals and families.

5. **Behavioural Support Ontario** - In January 2010, the Ministry of Health and Long-Term Care funded a working group to undertake the first phase of an Ontario Behavioural Supports System Project and develop a principle-based Framework for Care. The framework would enhance services for elderly Ontarians with complex and 'responsive' behaviours wherever they live – at home, in long-term care homes or elsewhere. Responsive behaviours are aggression, wandering, agitation as well as others and for many people are the trigger for a crisis visit to hospital and transfer to long-term care. The reasons identified to undertake this project were:
- The numbers of people at risk for responsive behaviours is increasing;
 - Challenges are experienced across all health sectors and services;
 - The person and family required better quality experiences;
 - There are significant costs associated with managing behaviours;
 - There are recognized best practices that could be more systematically adopted;
 - There is an opportunity to leverage existing initiatives in Ontario; and
 - There is a stakeholder readiness for change.
6. **CCAC Expanded Role** - In 2010, a LHIN/CCAC working group was established to define a consistent/common approach to ensure legislative changes to enable an expanded role for the CCAC. This group has defined how the expanded role should be implemented, outlined what needed to be done consistently across the LHINs and what flexibility would be required for local implementation.

The working group concluded that a more global review of the CCACs role was needed and it was agreed the focus of their work would be on:

- Defining a vision and directional plan for an expanded CCAC role within an integrated system; and,
- Developing a practical framework to support the consistent implementation of the CCACs expanded role in placement.

In late 2010, the 14 LHIN and 14 CCAC CEOs agreed upon carrying out the following five **Directions for Actions**:

1. To ensure the right care at the right place at the right time, the CCACs and LHINs are working in partnership to optimize CCAC capacity: i) to be the single point of access for defined health services; and ii) to be a connection for Ontarians to the most appropriate health care services.
2. CCACs will be the single point of access for expanded services for placement (i.e., adult day programs, complex continuing care, rehabilitation and supportive housing/assisted living). Access for placement will incorporate best practices and a standard approach throughout the province. Each LHIN/CCAC will develop an implementation plan for their area by March 31, 2011.
3. CCACs will be the single point of access for assisted living services described in the Assisted Living Services for High Risk Seniors Policy.
4. The practical steps and success factors identified through a survey and interviews with LHINs and CCACs will be used as a common, practical framework and provincial directional plan to implement the expanded role of CCACs. Each LHIN/CCAC will develop more detailed directional plans that will include deliverables, responsibilities and timelines.
5. Each LHIN/CCAC will determine whether to implement the opportunities associated with new prescribed services, new care settings and use of therapy assistants/aides given

that these implementations are highly dependent on local needs and circumstances (i.e. availability of health human resources, financial constraints). The CCACs will share best practices information to build on others' successes.

Communicating the Provincial LHIN Priorities

The overarching communications plan is a shared responsibility between the 14 LHINs, the MOHLTC and the Minister's Office. The plan speaks to both a shared communication strategy and communication and operational activities to be undertaken by all LHINs, specifically related to a number of LHIN priority projects. It is the platform upon which the LHINs reinforce the LHIN brand and value of the organizations in leading the important transformation of Ontario's health system.

It is to be noted that the progress of programs supporting the provincial LHIN priorities varies amongst the LHINs. For example, one LHIN may be deeply entrenched in one priority while at the planning stage of another. For this reason, the overarching plan provides a commonality from which each LHIN can then develop a local communication plan for specific initiatives. However, the communications objectives, target audiences and key messages developed in the overarching plan are to be incorporated into every local communications plan.

Strategic Objectives

- To raise the profile and demonstrate the value of LHINs at a provincial level.
- Create a communications campaign that highlights LHIN initiatives and promotes the value LHINs across Ontarians.
- Campaign is focused on "Access to Care".

Audiences (in order of importance)

- Public (Taxpayers, patients/clients and family members)
- Health Service Providers (funded and non-funded such as public health)
- Health Service Provider Governance representatives
- Physicians (specialists & general practitioners)
- Local government stakeholders (municipal & provincial)
- Premier
- Minister of Health and Long-Term Care
- Minister's Office
- Ministry of Health and Long-Term Care
- Media

Role of the LHIN

LHINs bring together health care partners from the following sectors – hospitals, community care, community support services, community mental health and addictions, community health centres and long-term care – to develop innovative, collaborative solutions leading to more timely access to high quality services for the residents of Ontario and the North Simcoe Muskoka LHIN. By supporting these important partnerships, LHINs are ensuring that Ontarians have access to an effective and efficient health system that delivers improved health care results and a better patient experience.

Key Messages

- Because of LHINs, for the first time, providers in the local health system are **working together** to improve **access to quality care** for Ontario residents.
- Because of LHINs, for the first time, the health care needs of **people in your community** are being identified, coordinated and addressed as a **truly integrated system**.
 - Local residents are receiving the right care at the right time in the right place, at the right cost.
 - Hospitals and community partners are working together to reduce ER wait times and deliver greater access to care.
- Because of LHINs, for the first time, **local decisions** are being made to respond to local health care needs.
 - Every corner of this vast province has different health care needs. Those needs are best met through local decision-making.
 - By talking and listening to local health service providers and community residents, LHINs identify and bring to life local initiatives.
 - Health care decisions are focused on quality and with an understanding of the diverse and unique needs of each community.
- Because of LHINs, for the first time, health service providers, such as hospitals, long-term care homes and community agencies, are being held **accountable for the taxpayer dollars** they are given.

On-going collaboration among the 14 LHINs will ensure that a consistent message is delivered across the province for provincial priorities, while the development of local communications plans to support specific projects or programs will ensure that local priorities are addressed.

Appendix A

Glossary of Terms

Annual Business Plan
2012 - 2013

North Simcoe Muskoka LHIN – Annual Business Plan

Glossary of Terms

ABI	Acquired Brain Injury Organization
ABP	Annual Business Plan
ACC	Accountable Coordinating Council
ACS	Acute Coronary Syndrome
AFHT	Algonquin Family Health Team
AHC	Aboriginal Health Circle
AIC	Arthroplasty Intake Clinics
ALC	Alternate Level of Care
ALO	Accountable Lead Organization
ALSSH	Assisted Living Services in Supportive Housing
AMI	Acute Myocardial Infarction
AoF	Area of Focus
BCFHT	Barrie & Community Family Health Team
BCHC	Barrie Community Health Centre
BDDI	Baseline Diabetes Dataset Initiative
BFHT	Bracebridge Family Health Team
BORN	Better Outcomes & Registry Network Ontario
BSS	Behavioural Support Services
CC	Care Connections
CCAC	Community Care Access Centre
CCC	Complex Continuing Care
CCFHT	Cottage Country Family Health Team
CCHC	Chigamik Community Health Centre
CCO	Cancer Care Ontario
CDPM	Chronic Disease Prevention and Management
CEO	Chief Executive Officer
CFHT	Couchiching Family Health Team
CGMH	Collingwood General and Marine Hospital
CHC	Community Health Centre
CHF	Congestive Heart Failure
CSS	Community Support Service Organization
CT	Computerized Axial Tomography
CTAS	Canadian Triage and Acuity Scale
DEC	Diabetes Education Centre
DRCC	Diabetes Regional Coordination Centre
ED	Emergency Department
ED PIP	Emergency Department Process Improvement Program
EMR	Electronic Medical Record
EMS	Emergency Medical Services
ER	Emergency Room
ER/ALC	Emergency Room / Alternate Level of Care
FLHPE#4	French Language Health Planning Entity #4
FLS	French Language Services

FNMI	First Nation Métis Inuit
FTE	Full Time Equivalent
GBFHT	Georgian Bay Family Health Team
GBGH	Georgian Bay General Hospital
GI	Gastrointestinal
HHR	Health Human Resources
HOOPP	Healthcare of Ontario Pension Plan
HQO	Health Quality Ontario
HSAA	Hospital Service Accountability Agreement
HSPs	Health Service Providers
ICD	Implantable Cardioverter-Defibrillator
ICT/eHealth	Information Communication Technology / eHealth
IHCC	In-Home and Community Capacity
IHSD	Integrated Health System Design
IHSP	Integrated Health Service Plan
IRFP	Integrated Regional Falls Program
IT	Information Technology
LDL	Low Density Lipids
LHIN	Local Health Integration Network
LHIN LC	Local Health Integration Network Leadership Council
LHINC	LHIN Collaborative
LHSIA	Local Health System Integration Act
LLC	Local Leadership Council
LOS	Length of Stay
LSSO	LHIN Shared Services Office
LTC	Long-Term Care
LTCH	Long-Term Care Home
MAHC	Muskoka Algonquin Healthcare - Huntsville and Bracebridge sites
MAHC-H	Muskoka Algonquin Healthcare - Huntsville
MCH	Maternal and Child Health
MH&A	Mental Health & Addictions
MLPA	Ministry-LHIN Performance Agreement
MOHLTC	Ministry of Health and Long-Term Care
MPP	Member of Provincial Parliament
MRI	Magnetic Resonance Imaging
MSAA	Multi-Sector Service Accountability Agreement
NP	Nurse Practitioner
NSFHT	North Simcoe Family Health Team
NSM	North Simcoe Muskoka
NSM LHIN	North Simcoe Muskoka Local Health Integration Network
NSRDP	North Simcoe Regional Diabetes Program
ODS	Ontario Diabetes Strategy
OHA	Ontario Hospital Association
OMA	Ontario Medical Association
OPS	Ontario Public Service
OSMH	Orillia Soldiers' Memorial Hospital
P4R	Pay For Results
PCI	Percutaneous Coronary Intervention
PCMCH	Provincial Council for Maternal and Child Health

PIA	Physician Initial Assessment
PSC	Project Steering Committee
RCC	Responsible Coordinating Council
RLO	Responsible Lead Organization
RM&R	Resource Matching & Referral
RVH	Royal Victoria Regional Health Centre
SFHS	Senior Friendly Hospital Strategy
SGBCHC	South Georgian Bay Community Health Centre

Appendix B

Care Connections

North Simcoe Muskoka

Care Connections

Partnering for Healthy Communities

Annual Business Plan
2012 - 2013

North Simcoe Muskoka LHIN – Annual Business Plan

Appendix B – *Care Connections – Partnering for Healthy Communities*

Status of Each 'Area of Focus' and their Projects at end of 2011/12, and deliverables to end of 2014/15.			
Identified below are the 12 Areas of Focus (>40 Projects) to be implemented over the first 3 years (2011/12 - 2013/14) with progress achieved. Reorganization of the 'areas of focus' and the addition of projects reflecting alignment to updated provincial priorities appear in the 'CC Plan' since the Annual Business Plan was submitted in 2011/12. The engagement and creation of opportunities for involvement of people who live within North Simcoe Muskoka, including cultural diverse populations (i.e., Aboriginal People, Francophones, etc.) and 'persons with lived experience' (consumers of health care) will inform all 'areas of focus'.			
	2012/13	2013/14	2014/15
AREA OF FOCUS (AoF) #1: COMPLEX AND CHRONIC HEALTH NEEDS Accountable Lead Organization (ALO): Georgian Bay General Hospital Accountable Coordinating Council (ACC) Purpose/AIM: To oversee and ensure design and implementation of a comprehensive Complex and Chronic Health Needs Care System for the residents of North Simcoe Muskoka.			
PROJECT #1.1. COMPLEX CONTINUING CARE (CCC) Responsible Lead Organization (RLO): Muskoka Algonquin Healthcare Project Steering Committee (PSC) Purpose/AIM: To implement and ensure all residents of North Simcoe Muskoka will receive quality Complex Continuing Care appropriate to their needs. Goals/Objectives/Deliverables Implementation of LHIN-wide CCC System model arising from the 10-year <i>Care Connections – Partnering for Healthy Communities Plan</i> for years 1-3 of the 10-year plan: • Continue to implement the LHIN-wide CCC Program specific recommendations and those requiring collaboration with other health service providers across the continuum of care; • Operationalize the siting and sizing recommendation for 102 regional CCC beds based initially at MAHC, GBGH and OSMH; • Implement revised CCC patient definitions across all sites; • Collaborate with other health sectors to develop a process on how to transition inappropriate patients in CCC beds to best level of care in alternate settings; • Conduct a role review to determine the degree of involvement of staff in CCC admissions, patient flow, team leadership and discharge processes, with the consideration of attendant care services in this system; and • Implement a staffing model of care delivery that is agreed upon by nursing leadership CCC Program partners.	10%		

PROJECT #1.2. CHRONIC DISEASE PREVENTION AND MANAGEMENT (CDPM) RLO: Orillia Soldiers' Memorial Hospital Project Steering Committee (PSC) Purpose/AIM: To integrate, align and implement the Ontario Chronic Disease Prevention Management framework adapted locally to the NSM LHIN health system. Goals/Objectives/Deliverables Implementation of LHIN-wide model for Chronic Disease Prevention & Management (CDPM) by supporting LHIN-wide and provincial initiatives with an initial focus on diabetes: • Leverage provincial momentum and resources dedicated to diabetes agenda; • Enable coordination across multiple providers focused on CDPM/ kidney/diabetes, etc.; • Enable focus on health and wellness, prevention, and self-management which empower individuals to care for themselves; • Align resources and incentives with a commitment to continuous quality improvement; and • Ensure that the child and youth population is considered.	30%	50%	20%
PROJECT #1.3. BEHAVIORAL SUPPORT SERVICES (BSS) RLO: Alzheimer's Society of Greater Simcoe County Project Steering Committee (PSC) Purpose/AIM: To implement a comprehensive Behavioural Support System (BSS) for the residents of the NSM LHIN. Goals/Objectives/Deliverables Implementation of the LHIN-wide BSS Model recommendations for years 1-3 of the 10-year Plan are based on the system redesign goals of the provincial Behavioural Supports Ontario Framework and the local BSS Value Statement of – <i>I AM PERSON, HEAR ME, CARE WITH ME, KEEP ME WELL.</i> The BSS project is focused on older adults with cognitive impairments duet to dementia, mental health problems, addiction or other neurological conditions and associated responsive behaviours who are at the 'tipping point'. This means seniors living in the community or in a long-term care home who experience an acute decline or change in behaviour to the degree that it puts themselves and others at risk, and changes the environment to the degree caregivers are unable to safely manage the individual with behaviour(s) and express an urgent need for additional supports. The local BSS project will be built around the three pillars of the provincial Behavioural Supports Ontario Framework of: 1) System Coordination and Management; 2) Integrated Service Delivery; and 3) Knowledgeable Care Team and Capacity-Building. The deliverables are to: • Provide an inpatient care setting and programming to better meet the needs of a specialized population that currently may not receive appropriate care; and	50%	30%	20%

Enhance community care services and capacity to support individuals with behavioural needs within the system to care for this population.			
AREA OF FOCUS #2: BUILDING IN-HOME AND COMMUNITY CAPACITY (IHCC) ALO: Orillia Soldiers' Memorial Hospital ACC: Purpose/AIM: To coordinate the design and implementation of strategies to support and sustain in-home and community capacity to ensure that patients/clients have access to the most appropriate level of care for their needs. This is evidenced through: - Improved Access to Care by reduced Alternate Level of Care (ALC) days; - Decreased use/demand for long-term care beds; and - Support to ensure appropriate use of emergency rooms. Goals/Objectives/Deliverables - Revise the current NSM LHIN ER/ALC Strategy to create a NSM LHIN In-Home and Community Capacity Strategy; - Oversee and ensure the implementation of local and provincial priorities linked to in home and community capacity, including recommendations arising from Care Connections; - Review and stay abreast of provincial direction with regard to ALC particularly the recommendations released in the recent <i>Caring for Our Aging Population and Addressing Alternate Level of Care (The Walker Report), June 2011</i>; and - Respond to and advise NSM LHIN regarding ALC current and future investments.			
PROJECT #2.1. ALTERNATE LEVEL OF CARE (ALC) RLO: North Simcoe Muskoka LHIN Project Steering Committee (PSC) Purpose/AIM: To improve patient flow by implementing strategies focused on Alternate Level of Care reduction to achieve the targets outlined in the 2010 NSM LHIN ER/ ALC Strategy: Goals/Objectives/Deliverables - Define key strategies at the local and LHIN level (including the roles of individual organizations, Task Force members and the LHIN) to facilitate the roll-out of the ALC Project across the NSM LHIN; - Prioritize strategies at the local and LHIN level to support a coordinated and collaborative approach to the planning and implementation of ALC strategies; - Implement ALC strategies at the local and LHIN level to achieve desired system outcomes in alignment with targeted timelines; - Increase local and LHIN level capacity in regard to ALC reduction and management, including standardization of practices, programs and policies where appropriate; - Evaluate and monitor the roll-out of the ALC Project, including the development of performance measurements; - Ensure regular and timely communication regarding ALC progress is disseminated to key stakeholders and others as appropriate; and - Develop and implement a community engagement plan to facilitate the uptake and roll-out of the ALC Project across the NSM LHIN.	60%	20%	20%

PROJECT #2.2. HOME FIRST RLO: NSM Community Care Access Centre Project Steering Committee (PSC) Purpose/AIM: Lead action to assist in enabling residents of NSM to receive care at home to the maximum extent possible and reducing utilization of Emergency Department and overnight care in other settings. To develop and implement programming to support successful uptake and sustainability of a Home First philosophy in the NSM LHIN and contribute to achieving outcomes of the In-Home and Community Capacity Coordinating Council. Goals/Objectives/Deliverables • Implementation of the Home First philosophy across the NSM LHIN in accordance with provincial directions, including: - o Setting the pace (phased timeline) and targets/goals for “Home First” consistent with the vision, mission, values and organizational structures of participating organizations; - o Roll-out of the provincial Home First Implementation Guide & Toolkit; and - o Roll-out of the provincial and local Home First Communication plan. • Implementation of LHIN-wide Home First recommendations arising from the 10 year <i>Care Connections – Partnering for Healthy Communities Project</i>.	70%	20%	10%
PROJECT #2.3. SENIOR FRIENDLY HOSPITAL STRATEGY (SFHS) RLO: Orillia Soldiers’ Memorial Hospital Project Steering Committee (PSC) Purpose/AIM: To roll out the provincial Senior Friendly Hospital Strategy across hospitals in the North Simcoe Muskoka LHIN. Goals/Objectives/Deliverables The primary goal of the SFHS is to enhance the care of seniors within hospitals and reduce the risk of functional decline while recovering from illness. This will provide seniors with a higher quality of life and with an increased capacity to live independently in the community. Through a SFHS approach to care, organizations will reduce ER wait times, acute length of stay and Alternate Level of Care days. • Review findings of the SFHS organization level report, NSM LHIN report and provincial report to define a LHIN-wide approach to senior friendly hospital planning. • Define key strategies at the local and LHIN level (including the roles of individual organizations, Task Force members and the SFHS Coordinator) to facilitate the roll-out of the SFHS across the NSM LHIN. • Prioritize strategies at the local and LHIN level to support a coordinated and collaborative approach to SFHS planning and implementation. • Implement SFHS strategies at the local and LHIN level to achieve desired system outcomes in alignment with targeted timelines. • Increase local and LHIN level capacity in regard to senior friendly	50%	30%	20%

environments, including standardization of practices, programs and policies where appropriate. • Evaluate and monitor the roll-out of the SFHS, including the development of standardized evaluation criteria. • Ensure regular and timely communication regarding SFHS progress is disseminated to key stakeholders and others as appropriate, including communication as per the provincial SFHS communication plan. • Develop and implement a community engagement plan to facilitate the uptake and roll-out of the SFHS across NSM hospitals. • Collaborate with the NSM LHIN in the roll-out of the provincial SFHS, including developing and submitting relevant literature, briefing notes and reports.			
AREA OF FOCUS #3: MATERNAL AND CHILD HEALTH (MCH) ALO: Orillia Soldiers' Memorial Hospital ACC: Purpose/AIM: To design, implement and provide leadership in advancing the care and service delivery models for the Maternal, Newborn, Child and Youth populations in NSM LHIN.			
PROJECT #3.1 MATERNAL AND CHILD HEALTH (MCH) COMMUNITY OF PRACTICE RLO: Orillia Soldiers' Memorial Hospital Project Steering Committee (PSC) Purpose/AIM: To implement the recommendations of the Provincial Council for Maternal and Child Health (PCMCH) with respect to the creation of a LHIN based Maternal/Child community of practice. Goals/Objectives/Deliverables • Promote evidence-based/best practices, thereby standardizing the level of care within the region and across regional boundaries; • Facilitate implementation of regional and provincial initiatives (LHIN/PCMCH/BORN Ontario); • Provide advice to LHIN/PCMCH regarding maternal-newborn/child and youth issues; • Support knowledge translation through peer communication, coaching and mentoring among service providers across the continuum of care re: maternal, newborn, child and youth and other communities of practice; • Create dynamic and collaborative mechanisms for system responsiveness; • Build partnerships/alliances; • Advocate for disease prevention, health and wellness along the continuum of care; • Promote and support research initiatives aimed at improving health and care; • Maintain a formal linkage with the Care Connections Child and Adolescent Mental Health and Addictions Steering Committee and provide advice and expertise to be reflected in recommendations to the Mental Health and Addictions Coordinating Council; • Maintain a formal linkage to Simcoe County Child Youth and Family Services Coalition; and • Ensure Mental Health needs within maternal, child, newborn sector are addressed.	70%	10%	10%

AREA OF FOCUS #4: MENTAL HEALTH AND ADDICTIONS

ALO: Waypoint Centre for Mental Health Care

ACC Purpose/AIM: To improve the care for individuals living with mental health and addictions conditions through implementation and continued development and refinement of the planning and design work completed by the Mental Health and Addictions (MHA) group of the NSM LHIN's Care Connections project.

Goals/Objectives/Deliverables

Oversee and ensure the implementation of LHIN-wide Mental Health and Addictions recommendations arising from Care Connections, specifically the following:

- To oversee a comprehensive redistribution of Schedule 1 beds for the NSM LHIN (11 Waypoint beds to RVH and 20 to GBGH);
- To build child and adolescent mental health capacity in the NSM LHIN;
- To enhance crisis management and community resources for mental health and addictions; and
- Continue to develop and refine the planning and design work completed to date, and recommend additional activities as may be required.

PROJECT #4.1: REDISTRIBUTION OF 31 SCHEDULE 1, ADULT MENTAL HEALTH BEDS

RLO: Waypoint Centre for Mental Health Care

Project Steering Committee (PSC) Purpose/AIM: To oversee a comprehensive redistribution of Schedule 1 Beds for the NSM LHIN, as approved by the NSM LHIN Board in 2010, specifically 11 Waypoint beds will go to RVH (2012/13) and 20 to GBGH (2013/14).

Goals/Objectives/Deliverables

Implementation of LHIN-wide Redistribution of Schedule 1 Beds recommendations arising from the 10 year *Care Connections – Partnering for Healthy Communities Project*. Recommendations for years 1-3 of the 10-year plan.

- Review Care Connections Mental Health and Addiction vision elements, guiding principles and proposed model of care to ensure a shared understanding as to the outcome to be achieved through the redistribution of beds;
- Determine core programs and services that will be delivered at each of the receiving hospitals as a result of the bed transfers, subject to Health Service Provider Board approval;
- Make recommendations on the guiding principles being incorporated into transfer agreements to be developed between Waypoint and RVH and between Waypoint and GBGH;
- Establish work groups, one between Waypoint and RVH and one between Waypoint and GBGH, to prepare transfer agreement recommendations for review by each of the respective hospital board;
- Prepare a plan, subject to Health Service Provider Board approval, for implementation of a single integrated system of acute care beds with common best standards, protocols and best practices, and shared efforts to ensure that all residents have access to timely, high quality comprehensive acute care services. The plan should identify specific administrative or clinical leadership roles that may be required to support the implementation of an integrated system and estimated associated costs;

50%

40%

10%

• Make recommendations on how the reconfigured, integrated acute care system will most effectively interface with community and tertiary partners; and • Establish and implement a plan to support GBGH in their process of becoming a Scheduled psychiatric facility. (Note: Voluntary Integration supported by NSM LHIN Board, Dec 2011)			
PROJECT #4.2: BUILDING CHILD AND ADOLESCENT MENTAL HEALTH CAPACITY IN THE NSM LHIN RLO: Waypoint Centre for Mental Health Care Project Steering Committee (PSC) Purpose/AIM: To build child and adolescent mental health capacity in the NSM LHIN, as approved by the NSM LHIN Board in 2010. Goals/Objectives/Deliverables Implementation of LHIN-wide Child and Adolescent Mental Health and Addictions recommendations arising from the 10 year <i>Care Connections – Partnering for Healthy Communities Project</i>. Recommendations for years 1-3 of the 10-year plan. • Achieve shared understanding as to the outcome to be achieved in the development of a comprehensive child and adolescent strategy; • Review Simcoe County Coalition Strategy plan to ensure alignment with existing efforts and opportunities; • Prepare a review of current needs, issues, opportunities and existing efforts; • Prepare specific service development recommendations including the following: • On how to enhance primary health care capacity; • On how to enhance community-based mental health service capacity; • On how to provide specialized consultation, including tele-medicine; • On the development of in-patient child and adolescent inpatient services; • On a model for an effective integrated system; • Identify service development priorities and associated costs, and make recommendations on implementation staging; and • Steer the incremental implementation of recommendations, subject to approval of affected HSPs and other affected organizations.	70%	10%	10%

PROJECT #4.3: ENHANCING CRISIS MANAGEMENT AND COMMUNITY RESOURCES FOR MENTAL HEALTH AND ADDICTIONS.

RLO: Canadian Mental Health Association, Simcoe Branch

Project Steering Committee (PSC) Purpose/AIM: To enhance crisis management and community resources for mental health and addictions within the NSM LHIN, as approved by the NSM LHIN Board in 2010.

Goals/Objectives/Deliverables

Implementation of LHIN-wide MHA Crisis Management and Community Resources recommendations arising from the 10 year *Care Connections – Partnering for Healthy Communities Project*. Recommendations for years 1-3 of the 10-year plan.

- Define future vision of 'local' mental health and addictions services;
- Refine current state inventory to assess the mix of services offered by planning area;
- Compare the future vision of local services to the current state inventory to assess gaps and future service need by each planning area;
- Prepare and implement a plan to enhance crisis management and community resources with regard to after-hours coverage by existing services, support to emergency departments and other providers, and timely care to address urgent MHA concerns;
- Prepare plan to expand community crisis intervention, including community withdrawal resources;
- Develop and implement standards of care for treating specific MHA populations;
- Develop plan to integrate stepped care approach to care into mental health and addictions program;
- Implement stepped care approach;
- Design a visiting specialist program, and other mobile services, to expand access to MHA services for rural, remote or isolated communities;
- Inform the development and deployment of integrated screening programs to include particular MHA-related tools for specific age cohorts; and
- Develop repository of evidence-based screening and assessment tools to be accessed and used by health professionals.

70%

10%

10%

AREA OF FOCUS #5: MEDICINE

ALO: Royal Victoria Regional Health Centre (RVH)

ACC Purpose/AIM: The Medicine Coordinating Council works collaboratively to facilitate implementation of the planning and design work completed by the Medicine group of the NSM LHIN's Care Connections project. The goal is to improve the care and health outcomes for individuals requiring critical care services, emergency department services or cardiovascular and/or stroke healthcare.

Goals/Objectives/Deliverables

The implementation of LHIN-wide Medicine Program recommendations arising from Care Connections, specifically the following:

Critical Care:

- Build the foundation to develop and sustain an integrated critical care system across the LHIN that is aligned with and guided by the Critical Care Secretariat strategic initiatives and

recommendations for all Ontario hospitals.

Cardiovascular:

- Develop a comprehensive cardiovascular program aligned with the Ontario Integrated Vascular Health Strategy; and
- Implement recommendations of the NSM LHIN Cardiovascular Steering Committee.

Stroke:

- Review and redesign Stroke Rehabilitation in the NSM LHIN (as defined within the scope of the 'Case for Change').

Emergency Department:

- Develop and Emergency Medical system which supports quality care of patients and staff is aligned with Emergency Department LHIN Lead strategic and provincial initiatives; and
- Plan, implement and evaluate the wait times in emergency department by CTAS levels, time to Physician Initial Assessment (PIA) and admit to inpatient unit targets.

PROJECT #5.1 IMPLEMENTING THE LHIN-WIDE CRITICAL CARE SYSTEM

RLOs: RVH and NSM LHIN (Critical Care Physician Lead and LHIN)

Project Steering Committee (PSC) Purpose/AIM: To implement a comprehensive Critical Care Program for the NSM LHIN, as approved by the NSM LHIN Board in 2010.

Goals/Objectives/Deliverables

Implementation of LHIN-wide Critical Care Program recommendations arising from the 10 year *Care Connections – Partnering for Healthy Communities Project*.

- Create and define the role and responsibilities of a regional critical care system coordinator. The coordinator will be responsible for improving local and regional critical care capacity and expertise, process and patient outcomes and resource utilization. The coordinator will be responsible for monitoring, analyzing and reporting the critical care performance and quality benchmark indicators for the regional critical care system and using this information to guide system improvement projects and intervention;
- Develop and implement a regional process that facilitates rapid local approval of regional critical care initiatives;
- Develop, disseminate, implement, evaluate and update standardized care process protocols whose purpose is to increase the compliance rates with best practices for critically ill patients;
- Create a regional referral communication plan to facilitate and ensure timely access to intensivist expertise and/or services;
- Define the criteria, roles and responsibilities for regional referral critical care centres that will not only support intra-LHIN patient transfers when indicated, but will also provide comprehensive consultative advice through emerging medical technologies, such as eHealth initiatives;
- Support the LHIN's plan to increase capacity for inter-hospital emergency medical system land transfers through the training/hiring of advanced care paramedics;
- Support the LHIN's plan to create inter-hospital patient repatriation agreements needed to ensure access and efficient utilization of critical care resources;
- The regional critical care system plan does not intend to replace or

70%

10%

10%

supersede the governance structures, committees and accountabilities of local critical care programs, nor does the plan challenge the autonomy of physicians or local critical care programs to care for patients, but rather the plan seeks to enhance the competencies and capabilities of local systems and care providers to care for the critically ill patient.			
PROJECT #5.2: NSM LHIN-WIDE CARDIOVASCULAR AND STROKE SYSTEM ALIGNED WITH THE ONTARIO INTEGRATED VASCULAR HEALTH STRATEGY RLO: Royal Victoria Regional Health Centre (RVH) Project Steering Committee (PSC) Purpose/AIM: To implement a comprehensive Cardiovascular Program for the NSM LHIN, as approved by the NSM LHIN Board in 2011. Goals/Objectives/Deliverables • Develop a committee jointly responsible for vascular and cardiac initiatives with focus on specific initiatives; to reach potentially marginalized members of our population and remove barriers to access to care; • Explore opportunities to coordinate funding and service delivery; • Expanded use of cardiac care maps and standardized orders across the LHIN with Southlake Regional Cardiac Program to lead development; • Community-based Heart Failure/ Function clinics be expanded so that each of the five geographic regions in the NSM LHIN have one; • Establish a tertiary cardiac program with catheterization, Percutaneous Coronary Intervention (PCI), pacemaker and Implantable Cardioverter-Defibrillator (ICD) implantation capability at RVH, Barrie (Sited within our LHIN as an urgent priority and a component of the existing Regional integrated cardiac program based at Southlake). Cardiac surgery and Electrophysiology Studies (EPS) services would continue to be provided at the Southlake site; • Include in comprehensive program - diagnostic catheterization and PCI labs with Primary PCI, pacemaker and ICD implant, cardiac rehabilitation, advanced cardiac non-invasive diagnostics (stress and rest cardiac echocardiogram (ECHO), nuclear cardiology, cardiac (CT) and future cardiac MRI. The diagnostic catheterization/PCI components at the site should be fully integrated with facilities at the Southlake site. Cardiologists to have joint staff appointments; • Opportunities to coordinate catheterization/PCI blocks and primary PCI call coverage between the two sites to optimize manpower resources; one program with two tertiary sites; • Recruit a board certified cardiologist to each of the five geographic regions within our LHIN; • Develop separate funding envelope to allow for cardiac rehabilitation to be provided cost free to patients post Acute Coronary Syndrome (ACS) or cardiac revascularization when these services are provided in our LHIN and monies to rehab programs; • Opportunities to combine cardio and stroke rehab programs should be explored; • Request provincial Ministry of Health and Long-Term Care to review:	40%	40%	20%

- o Ambulance service funding and level of expertise across the province; - o Financial responsible for 100% of ambulance service funding; and - o Ability for equitable access to advanced paramedic care across the province.			
PROJECT #5.3: LHIN WIDE EMERGENCY DEPARTMENT SYSTEM RLOs: RVH and NSM LHIN (ED Physician Lead and LHIN) Project Steering Committee (PSC) Purpose/AIM: To improve emergency department (ED) services for individuals utilizing North Simcoe Muskoka hospitals through a reduction in morbidity and mortality and an increase in quality of care while continuing to provide comprehensive, coordinated and integrated systematic emergency care. Goals/Objectives/Deliverables • To maintain and improve a culture of care that centres on the patient experience with a focus on the reduction of harm and increased quality of care that is literature based; • To maintain and improve a culture of care that supports health human resources throughout the emergency department network continuum of care; • Improve integration of the Emergency Department across the health care system and with other parts of the hospital through collaboration between health care professionals, across health service and across service sectors focused and based on literature and evidence/experienced based care with patient oriented outcomes as the focus; • To standardize practice and policy to facilitate patient flow and improve system processes; • Address system gaps to improve service integration across the continuum of care; • To increase utilization of data to improve evidence based decision making with improved data access, collection and reporting through an IT support system with improved infrastructure support provided through multiple sources such as the MOHLTC and the LHIN; • Target, strategic and appropriate public education and support to facilitate system navigation and heighten awareness of options for care.	20%	50%	30%
AREA OF FOCUS #6: SURGERY ALO: Collingwood General and Marine Hospital ACC Purpose/AIM: To improve the surgical care for individuals living in North Simcoe Muskoka through the implementation of a comprehensive, coordinated and integrated surgical program. Oversee and ensure the implementation of a LHIN-wide Surgical Programs that collectively works to improve surgical care and make the best use of resources. • Continue to develop and refine the planning and design work completed to date, and recommend additional activities as may be required. • Identify and put in place processes to deal with potential impact to other clinical areas as the first LHIN-wide Musculoskeletal Program is implemented.			

PROJECT #6.1: ADVANCING THE LHIN-WIDE MANAGEMENT OF MUSCULOSKELETAL (BONE AND JOINT CARE) CARE RLO: Collingwood General and Marine Hospital Project Steering Committee (PSC) Purpose/AIM: To implement a comprehensive Musculoskeletal Care Program for the NSM LHIN, as approved by the NSM LHIN Board in February 2011. Goals/Objectives/Deliverables - To establish the structures and processes to support a LHIN-wide Musculoskeletal Program covering the care spectrum of ages with multiple health service providers and the patients. - Shared understanding as to the outcomes to be achieved in the development of a LHIN-wide Musculoskeletal Program - Develop an inventory of Existing Resources – this would include operating room, inpatient, outpatient and rehab capacity - Identify the need for potential future resource needs and determine capacity required - Common understanding and development of corridors of service for access within and outside of the NSM LHIN (local, LHIN-wide and provincial) - Timely access to musculoskeletal care by: - Making recommendations on access and capacity of surgical services (based on current and future demand). - Making recommendations on access and capacity and timely access to rehab services based on current and future needs. - Reviewing and recommending changes to repatriation protocols. - Implementing a patient registry that will use technology and ensure timely access to beds and surgical services. - Exploring expansion of the model of the Arthroplasty Intake Clinics (AIC) to all musculoskeletal needs. - Decreasing demand on surgical services by decreasing incidents of fractures through prevention programs and other strategies. - In collaboration with the Surgery Coordinating Council, developing recommendations on effective use of resources; surgical beds, human resources, equipment, etc. - Implementation of best practices and standards of care for Perioperative Care and Rehabilitation - Review and recommending requirements to timely access to diagnostic radiology and pathology. - Develop and standardize on-call and operating room frameworks that can be adapted for orthopedics or any other surgical service.	60%	20%	20%
SYSTEM ENABLERS			
AREA OF FOCUS #7: COMMUNICATION AND COMMUNITY ENGAGEMENT ALO: North Simcoe Muskoka LHIN Responsible Coordinating Council (RCC) Purpose/AIM: The Council will provide strategic advice on communication and community engagement	40%	40%	20%

needs for the implementation of <i>Care Connections</i> areas of focus, projects, issues, risk mitigation, and strategies. Goals/Objectives/Deliverables • Develop, seek input and maintain a shared <i>Care Connections</i> communication and community engagement plan which aligns with the Care Connections Implementation; • Provide advice and support to the NSM Leadership Council on matters related to communication and community engagement during the <i>Care Connections</i> implementation; • Ensure a consistent approach on addressing LHIN-wide <i>Care Connections</i> issues or initiatives; • Develop communication templates or toolkits to benefit Coordinating Councils and Project Steering Committees in helping improve communications with stakeholders; • Organize education sessions to build better communication capability and understanding for communicators; • Participate in major Leadership Council activities requiring support of Communications; and • Evaluate the effectiveness of the Council on an annual basis.			
AREA OF FOCUS #8: GOVERNANCE ALO: North Simcoe Muskoka LHIN RCC Purpose/AIM: To provide leadership to the Boards and Governors of health service provider and related organizations within the NSM LHIN to facilitate the transformation from a collection of individual organizations to one, broader, integrated health system. Goals/Objectives/Deliverables • Undertake a process to help Boards and Governors transform from being organizational-centric to, integrated health system-centric. The process will include developmental discussion, education and dissemination; • Develop/adopt a transformation model specifically to engage all Governors of Boards (HSP's and other providers) in the development of a new governance model; • Engage in education and knowledge transfer; • Develop governance guidelines for Care Connection Lead Organizations; and • Develop governance guidelines for all participating organizations.	40%	30%	30%
AREA OF FOCUS #9: IMPLEMENTING THE INFORMATION COMMUNICATION TECHNOLOGY /EHEALTH ENABLING STRATEGY AND PLAN ALO: North Simcoe Muskoka LHIN RCC Purpose/AIM: In collaboration with eHealth Ontario, develop and implement infrastructure and business solutions to bring all sectors to a baseline of connectivity and technological advancement to enable the Care Connections care and service delivery models. Goals/ Objectives/Deliverables To implement a comprehensive ICT/e-Health strategy for the NSM LHIN,	30%	40%	30%

as approved by the NSM LHIN Board in 2010. Implementation of LHIN-wide ICT/e-Health recommendations arising from the 10 year <i>Care Connections – Partnering for Healthy Communities Project</i>. Recommendations for years 1-3 of the 10-year plan are noted in this Project’s Charter. • To investigate and assess the current state of readiness and ICT/eHealth capability of a representative sampling of health service providers; • To identify existing integration activities in the Client related to provincial eHealth strategies; • To develop a LHIN vision and strategic direction for ICT/eHealth in NSM that is consistent with the Ontario MOHLTC and the health service sector’s eHealth directions; • To identify specific barriers and opportunities to address these partnerships, linkages and an NSM LHIN approach to health-related ICT; • To identify key ICT decision-making considerations and criteria for use in the NSM LHIN that will support the region’s vision to determine, from a systems perspective, priorities for NSM ICT development and investment; • To identify timelines, costs, benefits and strategies to implement the identified NSM priorities, with associated funding sources (i.e. the plan must contain specific, practical and realistic implementation strategies and associated business cases; • To identify the main elements of, options and recommendations for, ongoing ICT coordination (including operating models) in the NSM LHIN, as well as the potential for inter-client or LHIN-wide approaches; and • To develop a guiding framework for aligning Information Technology / Information Systems / Information Management / eHealth planning at the individual HSP level.			
AREA OF FOCUS #10: INTEGRATED HEALTH HUMAN RESOURCE STRATEGY AND PLAN ALO: North Simcoe Muskoka LHIN RCC Purpose/AIM: To create a health human resources strategy for North Simcoe Muskoka and provide strategic health human resources advice that informs decisions and enables system change. Goals/ Objectives/Deliverables • Create a ten year health human resources strategy and plan for North Simcoe Muskoka for physician resources and health human resources beginning with a three year plan to support implementation of clinician and service delivery models; • Provide strategic health human resources support to human resources practitioners supporting the Coordinating Councils and Project Steering Committees; • Identify and implement strategies to leverage provincial health human resources initiatives; • Act as a conduit for communication, collaboration, knowledge exchange and innovation, as it relates to health human resources and	20%	50%	30%

leverage and share health human resources leading practices across the system; • Build on existing change leadership framework and support tools for system implementation; • Liaise with other LHINs on related cross-LHIN issues, as required; and • Operate in a fiscally responsible manner for system-wide performance improvement.			
AREA OF FOCUS #11: SYSTEM NAVIGATION ALO: NSM Community Care Access Centre RCC Purpose/AIM: To coordinate the design and implementation of a comprehensive System Navigation system for the North Simcoe Muskoka Local Health Integration Network (NSM LHIN). Goals/ Objectives/Deliverables Ensure completion of project deliverables as outlined in the project charter related to Information and Referral, and Transitions to Levels of Care • Develop a LHIN-wide inventory of services (health and non-health) using existing infrastructure (211, ConnexOntario); • Develop and implement a process to maintain and refresh the developed LHIN-wide inventory by leveraging the process in place at 211/ConnexOntario; • Develop a repository for health education information for dissemination to the public and to health professionals; • Continue to evolve information and referral services and health care connection service; • Develop a repository for evidence-based screening and assessment tools to facilitate use by health professionals; • Implement inter-facility protocols with NSM hospitals and tertiary care providers to facilitate patient flow (complex and chronic , newborn/obstetrical/paediatrics); • Implement LHIN-wide protocols for discharge/transition planning from immediate response health service providers; • Develop an “unattached patient” protocol to support these patients during care transitions; and • Develop corridor of care partnership agreements (maternal newborn child and youth, medical, hip/femur).	50%	40%	10%
AREA OF FOCUS #12: TRANSPORTATION ALO: The County of Simcoe RCC Purpose/AIM: To coordinate the design and implementation of a comprehensive Transportation Plan to improve timely and seamless access to required health services. Goals/ Objectives/Deliverables Recommend a coordinated, integrated inter-facility transportation system that is person-centered, standardized, safe, efficient and cost effective. • Define process for communication and approval of recommendations for both Central and NSM LHIN; • Establish key transportation concepts/considerations for inclusion in project objectives by all Care Connections Coordinating Councils	50%	40%	10%

(inter-facility); • Clear definition for inter-facility and what it encompasses; • Complete a comprehensive needs analysis to enhance system capacity, patient flow management and resource requirements; • Review, incorporate and customize recommendations from all reports outlined in strategic alignment with this committee; • Identify roles and responsibilities of all transport and related agencies; • Development of a clinical-based decision tree for transportation needs; • Develop a comprehensive inventory of transportation services and funding sources ranging from acute care to community health care services; • Establish guiding principles for consideration in the development of transfer agreements between facilities including long term care; • Establish work groups as required to make recommendations; • Final plan to include process for funds to follow the patient to bring the concept of patient-centric care to the forefront of funding models; and • Prepare a plan subject to HSP approval for implementation of comprehensive transportation system. Increase community access to health care services through the optimization of existing infrastructure and identify alternative technologies and service delivery options. • Review and summarize existing reports to understand community needs in relation to access to health care; • Clear definition of community health care services and what it encompasses; • Establish key transportation concepts/considerations for inclusion in project objectives by all Care Connections Coordinating Councils (community); • Identify alternative technologies and service delivery options such as Ontario Telemedicine Network and enhanced clinical practice such as Nurse Outreach Programs; • Review of existing inventories of transportation services; • Review and analysis of existing funding sources and gaps in funding that need to be addressed; • Explore the development of community transportation agreements with existing service providers; • Establish work groups as required to make recommendations; • Prepare a plan subject to Health Service Provider Boards approval for implementation of comprehensive transportation system; and • Development of a clinical-based decision tree for transportation needs.			
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