



Annual Business Plan 2013 - 2014

North Simcoe Muskoka Local Health Integration Network
(NSM LHIN)

April 2013



Ontario

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

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introduction

As a key component of the Ministry / LHIN accountability framework, the North Simcoe Muskoka Local Health Integration Network (NSM LHIN) Annual Business Plan (ABP) 2013 – 2014 directly supports the LHIN's Integrated Health Service Plan (IHSP) 2013 – 2014 | [Healthy People. Excellent Care. One System.](#) It represents year three in the life of *Care Connections - Partnering for Healthy Communities*, the NSM LHIN's ten-year operational roadmap designed to bring about the vision of an integrated health system.

Through *Care Connections*, health system partners and communities from across the region have come together committed to the implementation of effective, collaborative strategies designed to improve service delivery and contribute to the needs and well-being of those we serve. In large part due to the conceptualization, development and subsequent implementation of *Care Connections*, the health system across NSM has come a long way in a relatively short period of time. As a result, it should be of no surprise that the NSM LHIN has chosen to stay the course; to maintain and build upon our gains with *Care Connections* remaining at the heart of IHSP 2013 – 2016. ABP 2013 – 2014 builds upon the success of previous year's and specifically captures changes planned for the upcoming fiscal year, and how the success of these changes will be measured.

As noted within IHSP 2013 – 2016, residents and health service providers across North Simcoe Muskoka place a high value on their health care system. Acutely aware of its importance and need to be responsive to people in their local communities, there is a mutually held belief that health care service delivery is best understood from the perspective of those receiving care.

The NSM LHIN and its Board of Directors would like to offer sincere thanks and gratitude to all of our health system partners who, with common purpose, have taken ownership and accountability for change and, through hard work, dedication, commitment and collaboration, have brought a bold vision to life. Equally important is a sincere appreciation for the countless residents who continue to be engaged in the process of bringing health care closer to home. You play an integral role in the development of your health care system and it could not be done without you!

While this ABP represents but a year in the life of an ongoing journey, the NSM LHIN remains committed to long-term sustainable change; a new way of thinking, acting and behaving. To this end, the NSM LHIN Leadership Council, Board of Directors and staff team are mindful that in a very real sense we have only just begun; that we have so much more to do on the road ahead. IHSP 2013 – 2016 and ABP 2013 – 2014 both reaffirm and recommit us to our basic tenets including a collective will to change, a focus on what we can control, careful attention to the changing landscape, open and honest dialogue, the courage to take risk, an awareness of organizational readiness and capacity and a realization that our relationships are very much interdependent.

We all have a role to play in the success of our health system; in pursuit of a common and collective vision...

[Healthy People. Excellent Care. One System.](#)

section 1 | context

1.1 The Ever-Changing Landscape

NSM LHIN ENVIRONMENTAL SCAN

Since the release of its first IHSP 2007- 2010, the NSM LHIN has come a long way in a relatively short (6 years) period of time. A constant, has been the need to remain flexible and adaptable in order to meet the demands of an ever-changing landscape. IHSP 2013 – 2016 and by extension ABP 2013 – 2014, requires more of the same.

The NSM LHIN Environmental Scan (Appendix A, IHSP 2013 – 2016) is an abridged version, compiled from the pan-LHIN Common Environmental Scan (Appendix B, IHSP 2013 – 2016). Information presented in the *Common Environmental Scan* was collectively proposed by all fourteen LHINs and prepared by members of the Health Analytics Branch of the Ontario Ministry of Health and Long-Term Care.

While the development of IHSP 2013 – 2016 and ABP 2013 – 2014 requires far more insight than can be provided by this type of scan alone, the scan does...

- provide an overview for a number of key characteristics related to local populations, services, utilization and health impacts
- serve as a catalyst for further discussion regarding local priorities and activities
- support the development of measureable baseline data in order to assess the impact of targeted change
- allow people to better understand and compare the impacts, issues and status of many important health system attributes.

Informing the Transformation and Collaboration Process

In 2011, the NSM LHIN was home to 461,700 residents; 3.5% of Ontario's population. By the end of IHSP 2013 – 2016, the population is projected to increase by 7.8% or just over 36,000 people, just shy of half a million people. Of further note, the NSM population is projected to rise by 35.6% to 630,000 in 2031.

In 2011, 15.9% of NSM seniors were 65 years of age and over; up from 14.7% in 2006. By 2016, NSM seniors will account for 18.3% of the population and 20.6% by 2021. Meanwhile, the number of seniors aged 65 and over is expected to more than double over the next 20 years, from 75,284 in 2011 to 164,257 or 26.2% of the population by 2031.

Within the NSM LHIN, ischemic heart disease, diabetes and lung, colon and colorectal cancers are the leading causes of death. The top ten leading causes of death account for 57% of deaths. Mortality rates for many health issues including influenza, pneumonia and diabetes, and rates of Potential Years of Lost Life (PYLL) for many issues such as cirrhosis and other liver diseases, intentional self-harm and diabetes are among the highest in the province.

We know the population of NSM is both growing and aging quickly. There is also a clear picture related to causes of mortality and those areas where preventative medicine and primary care can play a leading role toward the provision of the right care, at the right time and in the right place. IHSP 2013 – 2016 takes into account the diversity and locations of the population in respect of what services to prioritize and where to deliver them.

The aforementioned information has been used to inform *Care Connections*, the NSM LHIN's ten-year operational roadmap designed to bring about the vision of an integrated health system. Existing projects will be reviewed with an eye to validation, then completion. Building capacity within communities, to care for individuals as close to home as possible and ensure care is delivered in the appropriate location at the right time, will be top-of-mind. Specific attention will be given to the 1% of the population that utilizes 34% of health care resources.

Through the implementation of effective data management and eHealth initiatives (electronic / technology), the integration of information and technology will continue to be a catalyst for “one source of truth.” As we continue to meet the complex needs of an ever-changing population, we must effectively manage our Health Human Resources to support meaningful change including

volunteer and caregiver strategies and supports, standardized job profiling so as to meet the needs of community-based care and continued awareness of system capacity.

Care Connections is built around one simple but important premise, that local health care is best designed, implemented and evaluated by those that utilize, deliver and access its programs and services. From this perspective, residents across NSM and health system partners alike share a common belief in both the importance of the health care system and its responsiveness to the needs of people in their local communities; that together, with everyone taking responsibility for their role in the health care system, a truly integrated system can be achieved.

The structure supporting *Care Connections* is a shared leadership and responsibility model that fosters effective collaboration and, ultimately, accountability for improved outcomes from all of NSM's partners. In collaboration with its health system partners and local communities, the NSM LHIN is actively involved, engaged and participating in planning, implementing and making decisions for the future sustainability of the local health system.

1.2 Mandate & Strategic Directions | The NSM LHIN Transformation Model

PROVINCIAL CONTEXT

Established in 2005, LHINs are mandated to manage the planning, integration, performance and funding of the health system across Ontario. As crown agencies that work in partnership with the Ministry of Health and Long-Term Care (MOHLTC), LHINs provide leadership and accountability for the health system at the local level, ensuring the health needs of people are being identified, coordinated and addressed in a truly integrated system. It is by design that LHINs strategically plan in such fashion as to align with ministerial and government priorities.

Ontario's LHINs are responsible for the allocation of approximately half (\$22 billion in 2011) of provincial health care expenditures. Together with the MOHLTC, they align local and regional plans with provincial priorities in order to both improve access to care and ensure long-term sustainability of the health system.

Between April 2003 and March 2012 health sector funding in the provincial budget increased at an average annual rate of 6.1%, for a total increase of \$17.9 billion. With a need to curtail growing expenditures, if only to ensure the future sustainability of the health system, the government has indicated that funding for the health care system cannot continue to grow at past rates. If access to services and quality care are to be maintained and/or improved upon, such a position will necessitate better value for money from all parts of the health care system.

Aligned with ministry efforts, Ontario's LHINs are planning for changes to the health care system that enable delivery of the right care, in the right place and at the right time, promote value for the dollar and ensure resources are used in such a manner as to promote sustainability.

ALIGNMENT - PROVINCIAL PRIORITIES, LHIN SYSTEM IMPERATIVES & THE NSM LHIN IHSP

Ontario's Action Plan for Health Care is focused on three main areas:

- Keep Ontario Healthy
- Faster Access and a Stronger Link to Family Health Care
- Right Care. Right Time. Right Place.

Provincial LHIN System Imperatives and the NSM's vision - *Healthy People. Excellent Care. One System.*, align with these three areas (Table 1.2.1), guiding decisions regarding the allocation of resources to providers and the programs and projects that need to be funded locally. The NSM LHIN will work in partnership with the Ministry, health service providers and residents across the region to ensure a sustainable health system that delivers high-quality, person-centred healthcare for current and future generations.

As outlined in Table 1.2.1, three pan-LHIN System Imperatives easily coordinate with the Ontario Action Plan's three priorities, providing local guidance for the provincial vision. LHINs must be sure to protect the many advances they have made in improving wait-times, value for money, transparency and accountability. As a result, a fourth LHIN-system imperative - *Holding the Gains*, will help Ontario's LHINs make sound choices about local projects by ensuring that achievements made to date are not lost as new priorities are identified and actioned.

Ontario's Action Plan for Health Care	Fourteen LHINs System Imperatives	NSM LHINs IHSP 2013 – 2016		Alignment
Keep Ontario Healthy - Support to Become Healthier	Leading with quality and safety	Healthy People Excellent Care One System	Holding the Gains	Yes
Faster Access and a Stronger Link to Family Healthcare	Strengthening and enhancing access to primary care			Yes
Right Care, Right Time, Right Place	Enhancing coordination and transitions of care for targeted populations			Yes

Table 1.2.1 - Alignment

VISION – NSM's LOCAL HEALTH SYSTEM

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



Healthy People

At the centre - the heart - of North Simcoe Muskoka's health system are its PEOPLE; almost 462,000 people to be more precise. Represented by six overlapping circles, the health needs of our population – social, occupational, spiritual, physical, intellectual emotional, environmental, financial and mental wellness - are diverse and forever changing as they move through life and stages of health.

Excellent Care

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

One System

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

Regardless of their level or length of engagement with the health system, our goal is to ensure that North Simcoe Muskoka residents live healthy active lifestyles by making informed and safe choices that promote wellness of mind, body and spirit in order to be free of injury, pain or illness.

MISSION - TOGETHER ACHIEVING... BETTER HEALTH. BETTER CARE. BETTER VALUE

If NSM's vision is the "why" and the implementation of *Care Connections* (including ABP 2013 – 2014) is the "how", then its mission represents "what" health system partners are working to achieve.

Ontarians value and identify with principles that underlie our public health care system. Health service providers and residents across NSM are no different. There is a shared belief in the importance of the health system and its responsiveness to the needs of people in local communities. Health system partners and communities across the region are committed to working collaboratively to develop and implement effective strategies that improve service delivery and contribute to the well-being of those we serve.

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

In the NSM LHIN, it is recognized that transformation of the health system is the shared responsibility of many partners across the continuum of care including residents, people with lived experiences, their families and health care professionals. Through *Care Connections*, everyone takes ownership of their health system. This is demonstrated by the health system partners providing the leadership and accountability for deliverables and outcomes to be achieved for each of the "twelve areas of focus" (inclusive of the six clinical areas and six enablers).

Over the next three years, the *Care Connections* "twelve areas of focus" will remain the priority. The recommendations and deliverables established and put forward by the twelve Coordinating Councils, each responsible for an area of focus, represent the priorities for change.

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

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

By staying the course, gains that have been achieved over the first two years of implementation will be sustained.

VALUES – BE REAL. BE REVOLUTIONARY. BE COURAGEOUS.

NSM's values inspire a new culture that supports continuous improvement and learning. Engaging with purpose, modeling the way and exploring the possibilities are the behaviours required to support change while striving for a collective vision.

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

1.3 Overview | Current and Forthcoming Programs & Activities

The shifting landscape and changing environment necessitates the current local health system to be nimble, adaptable and ready to embrace change to support the vision. There are many new and exciting opportunities that will be realized over the next three years, the likes of which are only now beginning to align and support health system transformation in NSM. By being open, receptive and focused, these new and existing areas to lever success will intersect with the established culture, structure, and strategy of the *Care Connections* framework.

HEALTHY PEOPLE

Health Links

Ontario is improving local health care for seniors and people with complex conditions through the creation of Health Links. Health Links will bring together all health service providers in a community in order to better and more quickly coordinate local health care services for people who need them the most.

In the NSM LHIN, there are approximately 1,400 residents with multiple complex and chronic conditions who require repeated admissions to hospital and/or long length of stays; who access the system frequently and at multiple entry points, often defaulting to the emergency department, which can result in uncoordinated care. Specifically, the estimated annual total cost to the system is \$169M or \$123,000/pp. At 39%, Barrie & Area has the largest number of this attributed population, and 51% of the NSM LHIN's population resides in this geographic area.

The development of Health Links will move forward in the first two pilot areas of North Simcoe Muskoka (Barrie & Area and Collingwood / Wasaga Beach & Area) and actively be implemented in the remaining three geographic areas, along with a dispersed population Health Link model for Aboriginal People. The establishment of Health Links in our local communities will help health service providers stay connected every time an individual accesses health care, resulting in a better understanding of the person's needs and what services they need to get better. For residents, this new approach will mean that they get faster access to the right care by not having to answer the same questions every time they need care, getting the right medications, and experiencing smoother transitions between health care providers.

Quality Improvement is a cornerstone of *Care Connections* and so too must it be at the core of NSM Health Links; a systematic approach to making changes that lead to better patient outcomes (health), stronger system performance (care) and enhanced professional development. It draws on the combined and continuous efforts of all stakeholders — healthcare professionals, patients and their families, researchers, funders, planners and educators — to make better and sustained improvements. The NSM LHIN has established a strong partnership with Health Quality Ontario (HQO) and has built strong local capacity for quality improvement. Leveraging this relationship will be a key enabling partnership that will assist in the implementation of the new Health Links as well as the *Care Connections* 10 year strategic plan. HQO has the expertise, access to best practices, provide information on metrics and the ability to be a key contributing partner moving forward. An enhanced focus on quality improvement activities within the LHIN will begin to roll out this spring, beginning with Health Links.

LHIN wide quality improvement efforts will be based on an understanding of the system in which we function, the complexity of dealing with people, the variation of outcomes created by the system and the use of knowledge to influence those outcomes. Through quality improvement, initiatives will be applied by local staff and leaders who are proficient at problem solving and managing group dynamics, and involve the people being served in the design of how care is delivered. Quality Improvement science provides tools and processes to assess and accelerate QI efforts through testing, implementation and spread. Outcomes will be measured according to three sets of metrics including Operational - setting the stage for coordinated care, Results - moving the needle, and Evaluation – how we'll know we've arrived.

Health Links – Measuring Outcomes

Operational - setting the stage for coordinated care	1) Ensure the development of coordinated care plans for all complex patients 2) Increase the number of complex patients and seniors with regular and timely access to a primary care provider.
Results – moving the needle	1) Reduce the time from primary care referral to specialist consultation 2) Reduce the number of 30-day re-admissions to hospital 3) Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere 4) Reduce time from referral to home care visit 5) Reduce unnecessary admissions to hospitals 6) Ensure primary care follow-up within seven days of discharge from an acute care setting.
Evaluation – how we'll know we've arrived	1) Enhance the health system experience for patients with the greatest health care needs 2) Achieve an ALC rate of nine per cent or less 3) Reduce the average cost of delivering health services to patients without compromising the quality of care.

Health Links will measure results and develop plans to improve access to family / primary care for seniors and people with complex conditions; reduce avoidable emergency room visits; reduce unnecessary re-admission to hospitals shortly after discharge; reduce time for referral from primary care doctor to specialist appointment; and improve the person's experience during their journey through the health care system.

1% of the NSM Population

Those individuals living with complex and chronic health conditions require the appropriate level of care, in the right location at the right time. The individual's needs span across the continuum of care, yet because of the complexity of their health care needs, their interaction with the health care system is ongoing and longer lengths of stay can be required. Due to the high level of need for complex care, the costs associated with delivering the care appropriately at the local level does increase.

As Ontario's Action Plan indicated, 1% of the population accounts for 34% of health care spending; 10%, accounts for nearly 80% of the overall spending. In North Simcoe Muskoka 1,400 residents fall in the top 1% of the population utilizing \$169 million/yr. in health care costs. The average cost of care for an individual living with complex needs (top 1%) in North Simcoe Muskoka is \$123,000 annually.

As we plan for an integrated health system that will be sustainable in the future to meet the complex needs of the growing population and be adaptable to the evolving environment, collaboration amongst the health system partners will be crucial as new and innovative models of service delivery are developed to enhance a truly person-centred health system.

People with Lived Experience

The health status of the local population is impacted by many determinants of health, the impacts of which are best felt, told and understood by the individuals and families who have experienced care. Knowing that local health care is best planned, coordinated and integrated by those that live in North Simcoe Muskoka, these experiences are critical to affecting change in

such a manner as to make the health system better. The implementation of *Care Connections* is centred on the needs and experiences of people / clients / residents as the core of the health system.

Aboriginal Peoples

The improvement of Aboriginal health services is achieved through ongoing collaboration and dialogue with the local Aboriginal Health Circle (AHC) and Aboriginal Peoples as engaged members of *Care Connections* councils and project steering committees.

Moving forward, information gleaned from the Aboriginal Health Circle Symposium 2012, which identified the needs and health requirements of Aboriginal Peoples, will also prove to be an invaluable baseline of knowledge. Addressing equitable 'access' and 'accessibility' to culturally appropriate, sensitive and safe services are the areas of focus from which the planning, development and implementation of an integrated health system will occur.

Health Wellness and Health Equity

Being proactive by looking upstream at wellness care, equity and health promotion is a means to achieving the vision for Healthy People. Understanding the needs and health status of the population being served encourages a continued focus on keeping people well and healthy, in addition to prevention from disease and illness.

Health system planning across the *Care Connections* areas of focus will address equitable access to high quality care in order to meet the unique needs of the diverse population living in North Simcoe Muskoka, inclusive of vulnerable and marginalized populations, the Francophone population, First Nation, Métis and Inuit populations and other populations of interest.

Primary Care

Primary care and access to it is a major element of establishing a healthy population. Access to a variety of health service providers where and when the individual needs the service is a determinant of an individual's health. Over the term of IHSP 2013 – 2016 primary care providers, municipalities and both community and social service providers across the NSM LHIN will continue to engage in open dialogue on how best to improve and sustain coordination of planning, design, performance management and accountability for sustainable primary health care models. The linkage of planning for primary care and healthy communities will be embedded within the *Care Connections* structure and a priority as system transformation continues.

Health Quality Ontario's new bestPATH initiative (Person-centred, Appropriate, Timely Health Care) is a framework designed to guide the development of a high quality, coordinated care experience for individuals with complex chronic illness. Local primary care partners, along with the NSM LHIN will work in partnership to support the Ministry's focus on transitions-in-care, effective chronic disease management and patient independence and safety for those with chronic illness; all of which are aligned with Ontario's Action Plan for Health Care and *Care Connections*.

EXCELLENT CARE

French Language Services

The planning and implementation of French language services is administered by the twelve *Care Connections* areas of focus.

In NSM the French Language Health Planning Entity #4 plays a notable role in addressing the needs of the Francophone community. By advising the LHIN on how best to overcome existing barriers and how to improve access and accessibility to French language services, Entity #4 is helping to ensure the delivery of excellent care. Through the course of IHSP 2013 – 2016, Entity #4 will continue to build on and improve the current Joint Action Plan and the outlined deliverables that align with the needs of Francophones living in NSM.

Community Resilience and Capacity

Excellent care for NSM residents can be achieved by the local health system partners in each of the LHIN's five local geographic areas coming together collectively and collaboratively to improve capacity and resilience at the community level. By building off the establishment of Health Links at the local community level, this model and approach will serve to sustain and meet the needs of the local population, now and in the future.

Strengthening partnerships across the continuum of collaboration (Figure 1.3.1), to create efficiencies in delivering better care close to home, focuses on the needs of the population today but drives to achieve sustainable care for future generations.

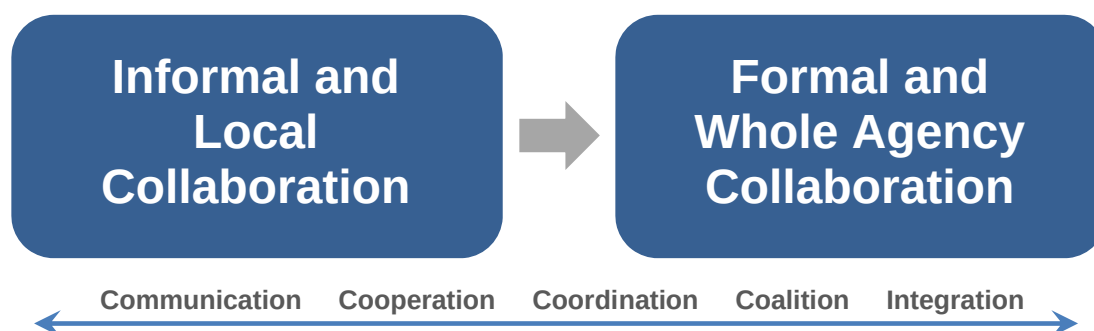


Figure 1.3.1 - Continuum of Collaboration

Health System Funding Reform

The new Health System Funding Report (HSFR) approach was introduced effective April 1, 2012 and has two components: the Health Based Allocation Model (HBAM) and Quality-Based Procedures (QBPs).

HBAM is an allocation model and management tool that uses demographic, clinical and financial information to estimate expected volumes of patients and costs at a facility level; this is then used to identify an organization's expected share of overall sector funding.

QBP's are targeted activities funded on a "price X volume" basis. They are funded based on evidence (e.g. utilization patterns, best practices) to encourage improvement in value for money, including improved outcomes and reduced variation across providers. Innovative solutions and approaches to new structures, models of care, funding, and resources to support system-wide and local improvements have to be integrated into the work of *Care Connections* moving forward.

Capital Planning

When it comes to delivering quality care to the residents of NSM, the unpredictable nature of the current economy and fiscal reality is a key factor that drives health system partners to collaborate and strategically think in new and innovative ways. As program and service delivery continues to transform into one system, the infrastructure needed to support models of care must also be considered within the planning equation.

Infrastructure planning for future population needs rests with the built environment of today. Innovative solutions and approaches to new structures, models of care, funding, and resources to support system-wide and local improvements have to be integrated into the work of *Care Connections* moving forward and the application of the Ministry-LHIN Capital Planning process.

ONE SYSTEM

Integration

The NSM LHIN's community engagement and communications activities have recognized that integration means different things to different stakeholders, and acknowledge that sectors and communities will be at different stages in their awareness, understanding and commitment to change. Boards of Directors, in particular, play a key role in health system integration. With responsibility for strategic direction, finances, quality and safety, and performance of their organizations, Board leadership will prove critical moving forward in achieving an integrated health system in NSM.

Shared Governance

Health system transformation will require Board Governors from across the system in North Simcoe Muskoka to collaborate. New conversations to define more formal whole agency collaboration and system-wide shared governance opportunities will be of priority amongst service providers, both at the local community and the system-wide level. Organizational accountability, along with system level accountability will be explored and understood as the performance outcomes are established for system integration, in order to achieve the vision.

Sharing the gains and making strategic re-investments collaboratively is paramount in re-engineering a system that will improve the quality of care our residents deserve and expect.

Quality Improvement

People living in the NSM LHIN share the common vision of a high-performance health system; a publicly funded system that is accessible, effective, safe, person-centred, equitable, efficient, appropriately resourced, integrated and focused on population health. These are the nine attributes of a high-quality health system identified by Health Quality Ontario (Figure 1.3.2).

The NSM LHIN is committed to the application of quality improvement science to achieve its strategic objectives as identified through *Care Connections*. The organization is a leader in establishing a culture of continuous quality improvement using structured improvement methods and models, including the Model for Improvement, Six Sigma and Lean.



Figure 1.3.2: Health Quality Ontario's Nine Attributes of Quality

Communications and Community Engagement

Open and effective communication and community engagement between the NSM LHIN, health system partners and residents of NSM, in addition to a host of additional stakeholders, is essential if an integrated health system is to develop and sustain itself. It forms the basis of lasting and meaningful relationships that are first and foremost based on mutual respect and trust.

The NSM LHIN will sustain this commitment to community engagement by building on the significant progress made to date with respect to the development of open and effective communication with many health system partners.

Project Management

Project management is the discipline of planning, organizing, securing, managing, leading, and controlling resources to achieve specific goals. The NSM LHIN is committed to project management and continues to train health system partners in using project management tools. By building this capacity within the local health system has led to a transformed culture of managing projects in a healthcare environment.

Section 2 | core content

2.1 the *Care Connections* 12 Areas of Focus

In the fall of 2012, the NSM LHIN Leadership Council strategically outlined the gains made through the committed work efforts and leadership of the *Care Connections* twelve Coordinating Councils, and advised where focus should be given over the next three years.

The *Care Connections* twelve areas of focus remain the priority for IHSP 2013 – 2016 and, as a result, ABP 2013 - 2014. By extension, the recommendations and deliverables established and put forward by the twelve Coordinating Councils will be the priorities for change. Staying the course allows gains from the first two years of implementation to be sustained. A renewed focus on routine, rigor and discipline helps to build on these gains; to accomplish additional achievements in pursuit of NSM LHIN's vision of an integrated health system.

The following pages outline the detailed work that will be the focus of the *Care Connections* 12 areas of focus for the duration of ABP 2013 – 2014. Projected stages of completion for specific deliverables are numerically quantified as a running completion percentage from left to right, and serve to demonstrate when the goal / deliverable will be completed in its entirety. With much of the implementation currently underway, attention should be placed on continued deliverables to be achieved over 2013/14 and 2014/15, through final completion.

To achieve the vision and sustain an integrated health system in North Simcoe Muskoka, the health system resources will shift, along with the expectation for the accountability. The seven Accountable Lead Organizations have demonstrated a commitment to change and provider Boards have signed accountability agreements and passed board motions to implement and share accountability for the deliverables of these areas of focus. The Accountable Lead Organizations are working together as a system and are accountable for the deliverables of each of their Coordinating Councils and corresponding Project Steering Committees, also led by a Responsible Lead Organization. Collaboration of partners for shared accountability and ownership across the system is a key factor in the achievement of the vision in North Simcoe Muskoka.

In moving forward this year, family and primary health care will have more prominence in the local health system with the establishment of Health Links across the communities and Aboriginal population in North Simcoe Muskoka. It is a system that will require integration of strategic planning and implementation of primary care into each of the twelve areas of focus to ensure accountability for the complete journey of the person across the continuum of care. People across NSM share the common vision of a high-performing health system. Based on HQO's nine attributes of quality, person-centred care is the heart of why shared accountability and change is required.

Complex & Chronic Health Needs

Purpose / Goal(s)

To design and implement a comprehensive Complex & Chronic Health Needs Care System for the residents of North Simcoe Muskoka.

System Aims

Person-Centredness – To improve person-centred care for persons living with complex and chronic health conditions.

Access – To improve access to care for persons living with complex and chronic health conditions.

Alignment

The work of the Complex & Chronic Health Needs Coordinating Council (CCHNCC) is aligned to Ontario's Action Plan by providing better care, better health and better value.

Work attributed to the Chronic Disease Prevention & Wellness Project Steering Committee reflects 'Keeping Ontario Healthy'. Activities of the Behavioural Support System (BSS) align with both 'Faster Access and Stronger Link to Family Health Care'. Meanwhile, the objectives for Complex Continuing Care (CCC) embody 'Right Care, Right Time, Right Place'.

The CCHNCC will oversee goals of respective Project Steering Committees with an eye to Health Wellness and Health Equity, and will facilitate collaboration with other Councils working in common areas of both impact and focus (i.e., In-Home & Community Capacity – Seniors Strategy, Health Links, Primary Care).

So too is the work of the CCHNCC aligned with the vision for bestPATH (person-centred appropriate timely healthcare) by being focused on improving health outcomes and system effectiveness through accessible and coordinated care for Ontarians with complex chronic illness.

Action Plans / Interventions

Accountable Lead Organization: Georgian Bay General Hospital	Year 3 – (ST) 2013/14		Year 4 – (MT) 2014/15		Year 5 – (MT) 2015/16	
	Status	%	Status	%	Status	%
Provincial Quality Campaign / Health Links						
Prevent avoidable readmissions; focus on transitions of care related to each population of focus in CCHNCC.	In progress	30	In progress	90	Will complete	100
Prevent avoidable institutionalizations: focus on adverse events.	In progress	10	In progress	50	Will complete	100
Prevent avoidable institutionalizations: focus on chronic disease management.	In progress	10	In progress	50	Will complete	100
Complex Continuing Care – Responsible Lead Organization: Muskoka Algonquin Healthcare						
Recommend a CCC bed registry approach for NSM LHIN.	Will complete	100				
Conduct utilization review and predict future CCC bed allocation in NSM LHIN.	Will complete	100				
Refine and determine CCC patient definitions for LHIN wide program.	Will complete	100				
Review and revise forms, procedures etc. to ensure alignment with the confirmed working definitions.	Will complete	100				

Examine patient outcomes e.g. patient satisfaction; length of stay; discharge destination; FIM scores (or other functional assessments) to understand the relationship, if any (statistical) between these patient outcomes and the models of care and resources available within CCC.	Will complete	100				
Develop a communication strategy which incorporates these key messages and disseminate to identified stakeholders.	Will complete	100				
Continue to evaluate the physician model of care and Nurse Practitioner role impact on CCC consistent with the requirements of the funding agreements.	In progress	50	Will complete	100		
Behavioural Support System – Responsible Lead Organization: Alzheimer's Society of Greater Simcoe County						
Cross boundary service evaluation and resolution through formalized relationships	Will complete	100				
Recommendations for service realignment / expansion of programs	Will complete	100				
Behavioural Intervention Response Team (BIRT) pilot in acute analyzed with recommendations for program	Will complete	100				
Evaluation recommendation implemented and risk to Mobile Support Team / project sustainability mitigated – transition ready as a program	Will complete	100				
Chronic Disease Prevention & Wellness – Responsible Lead Organization: South Georgian Bay CHC						
Website evaluation and sustainability plan complete	Will complete	100				
Self-Management deliverables related to spread achieved	Will complete	100				
Areas of focus identified for impact wellness and prevention of chronic diseases	In Progress	25	Will complete	100		
Activities aligned to Ontario Action Plan implemented in partnership with Simcoe Muskoka District Health Unit	In Progress	25	In progress	75	Will complete	100

Risks / Barriers to Successful Implementation

CCC

- Dedicated CCC Coordinator to assist in realizing identified goals is required
- Lack of available and reliable data to base recommendations
- Dedicated time (competing priorities) and prioritization to achieve identified goals
- When provincial resource matching and referral solution selected the need to migrate NSM bed registry information, practices and processes will be impacted
- Provincial shift in Rehab/CCC Alliance work may change processes/policies etc.

BSS

- Administrative / mobilization costs able to sustain the BSS mobile support teams
- MOUs to be signed by remaining LTCHs and community agencies supporting new HHR

CDP & Wellness

- Requirement to re-align Project Steering Committee's focus and development of a clear vision and objectives to be delivered
- Leadership identification for a new Chair as it relates to new focus and support of organizational board required to own accountability for deliverables
- System transformation and rollout of the provincial quality campaign may change prioritization of activities.

Key Enablers

Through the leadership of the Council and via recommendations by the Project Steering Committees, opportunities to enable the achievement of the goal will be addressed through the development of new and creative solutions to address:

- Dedicated System Coordinators and 'decision support' to perform the analysis required
- Access required for quality improvement / process mapping and the utilization of bestPATH tools; spread of self-management, etc.
- Strong connection required to the six enabler Coordinating Councils (System Navigation / eHealth / Integrated Health Human Resources, etc.).
- Linkage of Complex and Chronic Health Needs system-wide work into the development of the local Health Links being developed in 2013-14.

In-Home and Community Capacity

Purpose / Goal(s)

To support, sustain and expand in-home and community capacity to ensure that clients have timely access to the most appropriate level of care for their need; and to ensure a LHIN-wide Seniors' Care Strategy is in place that encourages and promotes the wellness and independence of older Ontarians.

System Aims

Access - To build and leverage in-home and community capacity to support individuals and caregivers to live at home independently and safely as long as possible.

Integration - To ensure individuals have access to and receive care in the most appropriate location provided by the most appropriate caregiver.

Person-Centeredness - To strive to ensure satisfaction with care experiences for people using in home and community capacity and their caregivers.

Alignment

The work of this Council has significant alignment with provincial priorities. To ensure the right care is provided in the right place, these goals and objectives focus on understanding and addressing the root causes of ALC, coordination / transition of care and system flow. By applying an upstream approach to health system transformation the goals and objectives directly align with provincial directions as outlined in reports like:

- Caring For Our Aging Population and Addressing Alternate Level of Care (2011) by Dr. David Walker
- Ontario's Action Plan for Health Reform (2012), Ministry of Health & Long-Term Care
- Living Longer, Living Well (2013) by Dr. Samir Sinha
- Ontario Action Plan for Seniors: Independence, Activity & Good Health (2013), Ministry of Health & Long-Term Care
- Recent Health Links 19 pilot site implementation and continuation of health links development across Ontario.

To achieve the NSM LHIN vision, accomplish the goals of the Coordinating Council, deliver on Care Connections recommendations and align with the provincial priorities outlined in Ontario's Action Plan for Health Care (2012), the In Home & Community Capacity will collaborate with appropriate Care Connection Councils and Committees to achieve the following goals and objectives:

Strive to ensure satisfaction with care experiences for people using in home and community capacity and their caregivers.

(RIGHT PLACE) Building and leveraging in-home and community capacity to support individuals and caregivers to live at home independently and safely as long as possible:

- Review and redesign existing service, programming, policies and processes to improve efficiencies and optimize resource utilization (work collaboratively with the two new and future developing Health Links in the five geographic areas and across the Aboriginal population and relaunch of Home First within NSM).
- In collaboration with appropriate sectors, evaluate what type of care can be most appropriately (better care, better value) shifted within and across the continuum (e.g. working in partnership with Health Links in 5 geographic areas).
- Support strategic investment planning to ensure new system capacity meets the needs of individuals and caregivers.

(RIGHT CARE) Ensuring individuals have access to and receive care in the most appropriate location provided by the most appropriate caregiver:

- Increase LHIN-wide understanding of the NSM LHIN 1-10% high users (to support the development of Health Links in the five geographic areas).
- Design and implement a LHIN-wide In-Home & Community Capacity Strategy to strive to ensure individuals and caregivers are receiving the right care in the right place at the right time.
- Improve the quality of care provided to area seniors and their caregivers by building an integrated continuum of seniors' health services in alignment with provincial initiatives like the Ontario Action Plan for Seniors and the Senior Friendly Hospital Strategy.

Action Plans / Interventions

Accountable Lead Organization(s): Independent Living Services of Simcoe County & Area and North Simcoe Muskoka Community Care Access Centre	Year 3 – (ST) 2013/14		Year 4 – (MT) 2014/15		Year 5 – (MT) 2015/16	
	Status	%	Status	%	Status	%
Revise the Terms of Reference and Project Charters for the IHCC Council and develop same for new IHCC Steering Committees.	Will complete	100				
Design a LHIN-wide In-Home & Community Capacity Strategy to guide future LHIN planning. <i>To consider: NSM LHIN Capacity Review outcomes; High User analysis outcomes; provincial, national and international best practices; innovation opportunities; Health Link development in 5 geographic areas & Aboriginal HL; provincial priorities and directions; Home First relaunch; implementation of CCAC Enhanced role; etc..</i>	Will complete	100				
Complete the NSM LTC Study to assess the current state of the NSM LTC system and identify opportunities for system redesign.	Will complete	100				
Complete a review of NSM High Users (top 1-10% of high cost / frequent users of health system in each geographic area) to inform Council's deliverables	Will complete	100				
Support roll-out of the Assisted Living Policy for High Risk Seniors.	In progress	80	Will complete	100		
Monitor the redesign of palliative care resources, based on strategic planning outcomes.	In progress	30	In progress	70	Will complete	100

Support implementation of a plan to shift appropriate clients from the CCAC to the Community Support Sector <i>(pending policy change)</i>	In progress	90	Will complete	100		
Monitor the roll-out of the Resource Matching & Referral project.	In progress	90	Will complete	100		
Support implementation of a Seniors' Care Strategy in NSM. <i>To use the NSM Seniors' Health Program Vision document (2009) as a foundation for planning and align, as appropriate, with the directions and recommendations within the Living Longer, Living Well provincial report.</i> <i>*(Continuing through 2016 - 17)</i>	In progress	25	In progress	50	In progress	75*
Facilitate completion of the provincial Senior Friendly Hospital Strategy <i>(Focus: functional decline and delirium in hospital).</i>	In progress	80	Will complete	100		

Risks / Barriers to Successful Implementation

- System collaboration and ownership that requires shared accountability and responsibility with trust and confidence amongst health system partners to be engaged in health system change and integration for the greater good
- Time and resources required by health system partners to administratively commit to the implementation of the Council goals and objectives, thus ensuring success and achieved outcomes
- The readiness to shift current or planned health service provider and LHIN resources / allocations in order to align with the MOHLTC strategies and investments to share gains and move from a hospital-centric system to a community and primary care focused system
- Significant and unexpected incidents which would put strain on the local health system, impacting patient flow. This would include incidents like outbreaks, pandemics and disasters
- 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
- 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. Pay equity continues to create pressures, especially in the Community Support Sector
- Public, health service provider and system readiness for change which challenges program uptake and success. Transferring care to the community, implementing the home first philosophy and piloting innovative models of service delivery all require a change in culture and practice with success contingent on readiness for change.

Key Enablers

- Provincial Planning. Work tied to provincial initiatives is, and will continue, to provide a strong foundation for local planning (e.g. Health Links development and deployment and Home First re-launch in NSM).
- Linkage of In-Home and Community capacity system-wide work into the development of the local Health Links being developed in 2013-14.
- *Care Connections - Partnering for Healthy Communities*, an infrastructure has been put in place to support planning, decision-making, change implementation and outcome evaluation across the NSM health system.
- System Leadership & Collaboration. Leadership by organizations in system change, collaboration between health service providers across the continuum of care AND designated leaders tasked with work plans and deliverables, will together enable success.
- Collective advocacy by the LHIN, organizations, providers and the public regarding system transformation to better match local needs with local resources.

Maternal, Newborn, Child & Youth Health

Purpose / Goal(s)

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.

System Aims

To improve effectiveness in obstetrics and paediatrics standards of clinical processes and frameworks across the acute care system within the next three years the Council will focus on the following system quality improvements:

- Safety
- Population Health

Alignment

The work of the Coordinating Council is aligned to:

- The Provincial Newborn and Child Council and the establishment of a Community of Practice locally.
- The overarching Vision: [Healthy People. Excellent Care. One System.](#)
- System-wide transformation | [Care Connections, Partnering for Healthy Communities](#) - Continuation of implementation of years 3, 4 & 5 of the 10 Year Integrated Health System Plan) with 12 Areas of Focus one of which is Maternal Newborn/Child Health.

Action Plans / Interventions

Accountable Lead Organization: Orillia Soldiers' Memorial Hospital	Year 3 – (ST) 2013/14		Year 4 – (MT) 2014/15		Year 5 – (MT) 2015/16	
	Status	%	Status	%	Status	%
Establish a dedicated maternal, newborn, child and youth (MCNY) council and reporting process that will provide LHIN wide leadership in advancing care and service delivery models	In progress	50	Will complete	100		
Conduct a gap analysis that evaluates why children may be travelling outside of NSM for health services with hospital, primary care and community services. This will also be considered in other parts of the Council's work. Children's mental health and complex children's navigation are completed			In progress	25	Will complete	100
Compare future vision of local services to current state inventory to assess gaps and future need by each local planning area. Gap identified for children's mental health-planning started.			In progress	50	Will complete	100
Incrementally build service capacity to address gap in MCNY services.			In progress	50	Will complete	100
Develop LHIN-wide standards of care.	In progress	10	In progress	35	Will complete	100
Implement a visiting specialist program to expand access to services for rural and remote communities.			In Progress	50	Will complete	100

Risks / Barriers to Successful Implementation

- With the lack of a full-time coordinator to coordinate this work, the efforts of the Council may take longer than other Councils to complete
- Resources required for the implementation of I.T. and software solutions which can enhance the system (i.e., flow, connection, exchange of information, client data sharing, etc.)
- One source of data is needed for the consistent use of valid data and interpretation by service providers

- Obstetrical resources are lacking / limited in NSM
- The work of this council involves three distinct ministries (MOHLTC, MCYS and Education) which is a challenge due to ministerial silos and required collaboration to overcome barriers and challenges.

Key Enablers

- Software, particularly those packages and linkages which ensure information and patient flow across the system
- Decision, performance and LHIN Liaison support for meeting the Council and Project Steering Committee deliverables
- Consistent shared vision of a Community of Practice and system-wide approach
- Health human resources for required service delivery models improvements.
- Linkage of Maternal, Newborn, Child & Youth Health system-wide work into the development of the local Health Links being developed in 2013-14.

Medicine

Purpose / Goal(s)

To work 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, integrated vascular and/or stroke healthcare.

System Aims

To provide timely, equitable access to medicine services with optimal outcomes for all in the North Simcoe Muskoka LHIN.

- Access
- Efficiency
- Safety

Alignment

The work of the Coordinating Council is aligned to:

- The overarching Vision: [Healthy People. Excellent Care. One System.](#)
- System-wide transformation | [Care Connections, Partnering for Healthy Communities](#) – Continuation of implementation of years 3, 4 & 5 of the 10 Year Integrated Health System Plan) with 12 Areas of Focus one of which is Medicine Council.

Action Plans / Interventions

Accountable Lead Organization: Royal Victoria Regional Health Centre	Year 3 – (ST) 2013/14		Year 4 – (MT) 2014/15		Year 5 – (MT) 2015/16	
	Status	%	Status	%	Status	%
Implementation of LHIN-wide Critical Care Program ▪ Develop and implement a regional approval process for regional critical care initiatives ▪ Develop, disseminate, implement, evaluate and update standardized care process protocols (including consistency with critical requirements). ▪ Create a regional referral communication plan. ▪ Refine the criteria, roles and responsibilities for regional referral critical care centres. ▪ Increase capacity for inter-hospital emergency medical system land transfers through the training/hiring of advanced care paramedics ▪ Create inter-hospital patient repatriation agreements.	In Progress	80	In progress	90	Will complete	100

Implementation of a comprehensive Vascular Program						
#1 Program Planning for the development of the PCI Program at RVH - Complete the MOU with Southlake Regional Health Centre; create program proposal; recruit health human resources; and develop functional program for Tertiary Cardiac Care program. #2 Facilitate the implementation of the Acute Coronary Care Syndrome across the LHIN - Develop project guidelines, approval process, implementation plan, conduct environmental assessment, obtain approvals and implement. #3 Implement enhanced stroke care units across the LHIN - Undertake an expression of interest process for siting and sizing of stroke care in NSM and conduct review and approval process for implementation. - Align implementation with the new HSFR funding model and that stroke is a Quality Based Procedure in 2013/14.	In progress	60	In progress	80	Will complete	100
To improve emergency department (ED) services for individuals 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. # 1– All emergency departments will provide evidence based care for patients admitted with sepsis through the ED. # 2– development and implementation of standard medical directives across all NSM EDs specific to Sepsis, Removal from Backboard, Gastro in children, Pain management, Super users of ED services # 3 – attaining standard access and process for consultative services for all ED Patients with an emphasis on plastics, orthopedics and mental health services by March 31, 2014. ED committee to work with Surgical committee to achieve this goal.	In progress	20	In progress	70	Will complete	100

Risks / Barriers to Successful Implementation

- Human resources for specific positions
- Need for all NSM EDs to participate in goal driven action plans
- Internal organizational processes that result in delay of approval to implement
- Implementing initiatives within current/planned health service provider, LHIN and/or MOHLTC resources or initiatives.
- Transportation
- Changing Ministry priorities.

Key Enablers

- Need for the LHIN to exercise their authority as per LHSIA to implement best practices
- Software and I.T., particularly those packages which ensure patient flow across the system.
- Linkage of Medicine system-wide work into the development of the local Health Links being developed in 2013-14.

Mental Health & Addictions

Purpose / Goal(s)

To improve the care for individuals living with mental health and addictions (MHA) conditions, thereby optimizing their health and well-being.

System Aims

- Access - To enhance the accessibility of mental health and addictions programs and services.
- Appropriate Resourcing - To ensure mental health and addictions programs and services are appropriately resourced and integrated.
- Equity - To ensure equitable, safe, timely access to a single regional system of high quality, person-centred acute care services delivered across three sites and fully integrated within the broader continuum of care.

Alignment

The work of the Coordinating Council is aligned to:

- Provincial Mental Health and Addiction strategy.
- The overarching Vision: [Healthy People. Excellent Care. One System.](#)
- System-wide transformation | [Care Connections, Partnering for Healthy Communities](#) - Continuation of implementation of years 3, 4& 5 of the 10 Year Integrated Health System Plan) with 12 Areas of Focus one of which is Mental Health and Addictions.

Action Plans / Interventions

Accountable Lead Organization: Waypoint Centre for Mental Health Care	Year 3 – (ST) 2013/14		Year 4 – (MT) 2014/15		Year 5 – (MT) 2015/16	
	Status	%	Status	%	Status	%
Develop a strategy to enhance MHA services for the child and youth population including hospital-based, community and primary care	In progress	25	In progress	50	Will complete	100
Incrementally build child and youth MHA service capacity	In progress	50	In progress	75	Will complete	100
Future vision for local MHA services have been completed integration has not been discussed. The future vision has been outlined but there has been no implementation of integration to date	In progress	10	In progress	55	Will complete	100
Develop and implement standards of care for treating MHA populations	In progress	10	In progress	35	Will complete	100
In collaboration with other programs, inform the development and deployment of integrated screening programs to include particular MHA-related tools for specific age cohorts. <i>*(Continuing through 2016 - 17)</i>	Children and adolescents: In progress Adults:	50	Will complete	100	In progress	75*

Building off existing tools, develop a repository of evidence-based screening and assessment tools accessed by health professionals	In progress	25	In progress	50	Will complete	100
Expand coverage of community crisis and intervention and community withdrawal management services to better meet the needs of NSM population			In progress	25	Will complete	100
Establish referral pathway between local police and MHA program	In progress	10	In progress	30	Will complete	100
Develop and deploy a strategy on how to engage employers as a partner in accommodating individuals with MHA illness					Will complete	100
Incrementally build service capacity to address gaps in MHA services and implement community integration strategies in planning area	In progress	25	In progress	50	Will complete	100
Leverage provincial efforts to design and deploy a community education campaign to reduce stigma and discrimination towards mental health and addictions issues. Coalition is engaged in this work. This work has not been direct work of our Councils to date but is part of the work plan.	In progress	25	In progress	50	Will complete	100
System Navigation - Make Community Connections/211 a single point of access for information and referral on mental health and addictions services	In progress	10	In progress	50	Will complete	100
Develop a plan to integrate the Stepped Care approach to care into mental health and addictions programs	In progress	10	In progress	35	Will complete	100
Leverage Aboriginal networks to help derive best practices developed by NSM and elsewhere to address the improvement of mental health and addictions services	In progress	25	In progress	55	Will complete	100
Design a visiting specialist program, and other mobile services, to expand access and accessibility to mental health services for rural, remote and isolated communities and for culturally specific groups such as Francophone and Aboriginal			In progress	50	Will complete	100
Expand coverage of community crisis intervention and community withdrawal management services to better meet the needs of NSM population	In progress	10	In progress	35	Will complete	100
Support the design of an adult mental health services continuum for the francophone community	In progress	25	In progress	75	Will complete	100

Risks / Barriers to Successful Implementation

- Implementation of initiatives within planned / current health service provider, LHIN and MOHLTC resources and allocations (health human resources, physical space, psychiatry) within the timeframe required or due to restraint be able to adapt and implement parts of the project
- Coding of presenting problems when reporting – need for standardization, definition and implementation (look at coding for emergency patients)
- A lot of people entering EDs are not connected anywhere in our system, potentially no service available, primary care access is also a part of the issue.

Key Enablers

- Enhancement and access to adequate public transportation, especially for those living in remote or rural areas of our LHIN
- Linkage of Mental Health and Addictions system-wide work into the development of Health Links in 2013-14.
- Technology such as OTN equipment, software which allows for better communication and patient placement, EMRs at all levels of our system and beyond (interministerial)
- Mobility of services-take the service to the person
- Common assessment tools, other standardized ways of doing our work.

Surgery

Purpose / Goal(s)

To improve the surgical care for individuals living in North Simcoe Muskoka through the implementation of a comprehensive, coordinated and integrated surgical programs.

System Aims

To provide timely, equitable access to orthopaedic care with optimal outcomes for all in the North Simcoe Muskoka LHIN to improve:

- Efficiency
- Effectiveness
- Access

Alignment

The work of the Coordinating Council is aligned to:

- The Provincial Orthopaedic Plan.
- The overarching Vision: [Healthy People. Excellent Care. One System.](#)
- System-wide transformation | [Care Connections, Partnering for Healthy Communities](#) - Continuation of implementation of years 3, 4 & 5 of the 10 Year Integrated Health System Plan) with 12 Areas of Focus one of which is Surgery.

Action Plans / Interventions

- Oversee and ensure the implementation of a LHIN-wide Surgical Programs that collectively works to improve surgical care and patient outcomes with the best use of resources.
- Continue to develop / refine the planning and design work completed, and recommend additional activities as required.
- Identify and put in place processes to deal with potential impact to other clinical areas as the first LHIN-wide Musculoskeletal (MSK) Program is implemented.
- Complete an inventory of surgical services available in the LHIN
- Complete a gap analysis of surgical services in the LHIN
- Determine priorities for reviewing all surgical services with identified timeline.

Accountable Lead Organization: Collingwood General & Marine Hospital	Year 3 – (ST) 2013/14		Year 4 – (MT) 2014/15		Year 5 – (MT) 2015/16	
	Status	%	Status	%	Status	%
Implementation of an Integrated LHIN-wide MSK program	Will complete	100				
Repatriation of elective surgeries occurring outside LHIN			In progress	50	Will complete	100
Development of integration proposal for plastics	In progress	75	Will complete	100		
Development and implementation of plastics			In progress	25	Will complete	100
Development of integration proposal for urology			In progress	25	Will complete	100

Risks / Barriers to Successful Implementation

- Funding to support the implementation of system-wide improvements within the current / planned health service provider, LHIN and/or MOHLTC resources or initiatives.
- Available time for committee members to complete tasks.
- Human Resources
- Outcome and impacts of Quality Based Procedures and the new funding model.

Key Enablers

- Health service provider / system partner leadership to influence change in this area of focus.
- Surgical System Coordinator required to implement the deliverables of the Council and Project Steering Committees.
- Linkage of Surgical system-wide work into the development of the local Health Links being developed in 2013-14.

Communications & Community Engagement

Purpose / Goal(s)

To provide strategic communication and community engagement counsel and recommendations to the Care Connections Coordinating Councils and their corresponding Project Steering Committees.

System Aims

- Effectiveness - To increase public awareness of Care Connections its concepts through media or other communication mechanisms.
- Effectiveness - To increase public knowledge of health information and services.

Action Plans / Interventions

Accountable Lead Organization: North Simcoe Muskoka LHIN	Year 3 – (ST) 2013/14		Year 4 – (MT) 2014/15		Year 5 – (MT) 2015/16	
	Status	%	Status	%	Status	%
Develop, implement and evaluate an overarching Care Connections Communication and Community Engagement Plan	Will complete	100	Implement: In progress Evaluate – Interim: In progress	 60 60	Implement: Will complete Evaluate – Interim: Will complete	 100 100
Provide recommendations forward to the Care Connections Operations Committee on consistent messaging.	Recommendations on consistent messaging ongoing with respect to changing issues, priorities and climate.					
Communicate the effectiveness of system-wide change initiatives.	Communication of system-wide change initiatives ongoing; aligned with individual Council implementation plans.					
Strategize around common communication and engagement opportunities, challenges and risks	Ongoing, based-on individual Council priorities and implementation plans.					
Participate in major Care Connections activities requiring support of Communications and Community Engagement.	Ongoing, based-on individual Council priorities and implementation plans.					
Evaluate the effectiveness of the Council on an annual basis.	Ongoing, based-on year end evaluation					

Risks / Barriers to Successful Implementation

- System collaboration and ownership that requires shared accountability and responsibility with trust and confidence amongst health system partners to be engaged in health system change and integration for the greater good.
- Time and resources required by health system partners to administratively commit to the implementation of Council goals and objectives, thus ensuring success and achieved outcomes.
- Successful integration and/or leveraging of existing communication tools and resources across all health service providers.

Key Enablers

- Effective and demonstrative leadership from all health service providers.
- Effective and meaningful knowledge exchange.
- Willingness for cultural change.
- Linkage of Communications / Community Engagement Council and system-wide work into the development of the local Health Links being developed in 2013-14 (especially as it relates to local community engagement and messaging to key stakeholders).

eHealth

Purpose / Goal(s)

To support the development of an integrated electronic system of health services that provides person-centred, timely, equitable access, high quality, evidence-based services in an efficient, effective and sustainable manner.

System Aims

- Efficiency – To provide strategic direction on all eHealth projects and initiatives within the LHIN.
- Integration – To provide oversight for the project planning and implementation of all provincial and six LHIN cluster level eHealth projects.
- Access – To act as the LHIN-wide Steering Committee on all eHealth projects where direct LHIN-level project management is required.

Alignment

eHealth Ontario was established by the provincial government in September 2008 as an independent agency of the Ontario Ministry of Health and Long-Term Care. eHealth Ontario is enabling physicians and health service providers establish and maintain electronic health records (EHRs) for all of Ontario's 13 million residents. NSM LHIN ensures that the local, cluster and provincial eHealth projects are integrated and promoted with all the electronic health systems in our LHIN.

Action Plans / Interventions

Accountable Lead Organization: North Simcoe Muskoka LHIN	Year 3 – (ST) 2013/14		Year 4 – (MT) 2014/15		Year 5 – (MT) 2015/16	
	Status	%	Status	%	Status	%
Collaborative Change - To assess readiness and conduct collaborative project management in order to effectively champion change for the implementation of provincial and local information management projects. ▪ Health Links Projects – Collaborate on all Information Technology requirements to ensure patient-centred approach in design of electronic solutions.	In Progress	25	In Progress	75	Will complete	100

– Ensure “Privacy-by-Design” in technology solutions compliant with PHIPA, 2004 legislation through Information and Privacy Commissioner of Ontario. ▪ Medication Management Systems – ePrescribing Project – Promote the successful pilot implementation between the hospital, the physicians and pharmacists in the Collingwood and surrounding area to ensure implementation in all of NSM LHIN.						
Continuous Improvement - To monitor and evaluate the implementation and outcomes for the sustainability of the information management projects: All implemented eHealth projects in NSM LHIN are designed to address the following: ▪ Improve integration and transitions of care ▪ Quality improvement and better health outcomes ▪ Sustainable financial performance and accountability ▪ Improve system access and capacity. This is accomplished through: ▪ Education for project leaders of Healthcare Service Providers. – Project Management 101/Eclipse PPM training to all Healthcare Service Providers continues. ▪ Formal Close-out reporting and transition to operational support for each eHealth project. This includes regular monitoring of project effectiveness against all measurable performance indicators and continuous Quality improvement. ▪ Gain sharing – the identification of real costs being saved through the use of technology implementations thereby creating a self-sustaining health system by recognizing the savings through LEAN streamlining.	In Progress	50	In Progress	75	Will complete	100

Capacity Building - To share knowledge, educate and develop awareness of health information management. - Community Care Information Management – Common Assessment Project; Integrated Assessment Record - Telemedicine Adoption Project.	In Progress	50	In Progress	75	Will complete	100
Standardization - To subscribe and adhere to a set of standards, policies and processes as established by Canada Health Info-Way and supported by the Council. The following provincial projects are governed by these standards: - connectingGTA - Ontario Laboratory Information System - Resource Matching and Referral - GTA West Diagnostic Imaging Repository - Hospital Report Manager	In Progress	50	In Progress	75	Will complete	100

Risks / Barriers to Successful Implementation

Partner with the Information and Privacy Commissioner of Ontario for all electronic health projects in NSM LHIN.

Key Enablers

- Ontario LHINS Privacy Toolkit completed by NSM LHIN in 2011. Privacy by Design, PHIPA, and 2004 legislation is foundational to all business plans and technology implementations.
- Cloud based Electronic Health Record solution to enable a patient-centred secure collaboration between Healthcare service providers and patients alike.

Governance

Purpose / Goal(s)

To provide leadership in the transformation of the NSM LHIN system of governance from an individual, provider-centric model to a person-centred model of collaborative governance characterized by health system and population health-based decision-making.

System Aims

Integrated - To increase the capacity of health service provider Boards to fulfill their governance mandates and responsibilities as set out in the Local Health System Integration Act (2006).

Alignment

In 2011, the LHIN Board of Directors approved the implementation of its newly designed 10-year (2010-2020) Integrated Health System Plan; *Care Connections – Partnering for Healthy Communities*. As a key enabler to implementing changes required, the Board established a Governance Coordinating Council to support health service provider Boards learn about and explore options for integration of service delivery across the LHIN.

Local Health System Integration Act, 2006 - The purpose of this Act is to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services; to coordinate health care in local health systems and across the province; and to effectively and efficiently manage the health system at the local level by Local Health Integration Networks. 2006, c. 4, s. 1. Under the Act:

- **Identifying integration opportunities**
24. Each LHIN and each health service provider shall separately and in conjunction with each other identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services. 2006, c. 4, s. 24.
- **Integration by networks**
 - 25. (1) A local health integration network may integrate the local health system by,
 - (a) providing or changing funding to a health service provider under subsection 19 (1);
 - (b) facilitating and negotiating the integration of persons or entities where at least one of the persons or entities is a health service provider or the integration of services between health service providers or between a health service provider and a person or entity that is not a health service provider;
 - (c) issuing a decision under section 26 that requires a health service provider to proceed with the integration described in the decision; or
 - (d) issuing a decision under section 27 that orders a health service provider not to proceed with the integration described in the decision. 2006, c. 4, s. 25 (1).

The *Care Connections* Plan is in alignment with Ontario's Action Plan for Health Care, 2012 and its' three priorities.

Action Plans / Interventions

Accountable Lead Organization: North Simcoe Muskoka LHIN	Year 3 – (ST) 2013/14		Year 4 – (MT) 2014/15		Year 5 – (MT) 2015/16	
	Status	%	Status	%	Status	%
Oversee the development of a new governance model for the health system that includes components noted in Action Plan.						
▪ Establish or adopt principles and protocols to guide health system provider governance level decision making	In progress	25	In progress	75	Will complete	100
▪ Establish or adopt dispute resolution mechanisms	In progress	50	Will complete	100		
▪ Establish Performance Metrics; a set of system metrics to which all Health Service Providers are held accountable	In progress	50	Will complete	50		
▪ Establish or adopt protocols that document expectations of the HSP board directors regarding fiduciary duty and conflicts of interest, and how these will be managed	In progress	50	Will complete	50		
▪ Establish communication policies detailing the processes and purposes of information sharing and decision making amongst the boards	In progress	50	Will complete	50		

Establish 'delegation of authority' mechanism that empowers leaders to commit organizations to system improvements, where possible	In progress	50	Will complete	50		
Establish tools to assess and support HSP boards in resource allocation decisions that will lead to a coordinated continuum of health	In progress	50	Will complete	50		
Align with supportive provincial legal framework.	In progress	50	Will complete	50		
Oversee the Development of a governance education plan for the health system						
Survey NSM LHIN HSPs needs in Board education on governance in a 'one health system' model/environment	In progress	50	In progress	75	Will complete	100
Develop compendium of existing governance education providers and related courses, materials, tools for board use, etc.	In progress	75	Will complete	100		
Establish Education Plan for the HSP Boards	In progress	75	Will complete	100		
Establish schedule of sub-planning area and LHIN-wide education sessions to end of 2013/14.	Will complete	100				

Risks / Barriers to Successful Implementation

- Insufficient time and resources to complete tasks in a timely fashion: Review proposed timelines and resource requirements with each project steering committee and make adjustments to ensure a manageable process.
- Evaluate and potentially reorganize existing activities and planning structures to allow focus on Care Connections.
- LHIN-funded Health Service Provider organizations may not have identified governance in a 'one system' model as a strategic priority for their organization: Work with each HSP to identify appropriate strategy for the individual organization that would support their journey in getting to the desired position.
- Work within current legislation created by the Government of Ontario and through opportunities for dialogue for the future state understand what may be required to foster the development of a 'one system' governance model: Monitor changes that may evolve over the course of the project; LHISA and other related legislation that impact the governance of HSPs, and align governance model to reflect any changes that may occur over time.

Integrated Health Human Resources

Purpose / Goal(s)

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.

System Aims

- Appropriate Resource - To improve resource allocation for people working in all sectors in North Simcoe Muskoka.
- Equity - To improve equity for people working in all sectors in North Simcoe Muskoka.

Action Plans / Interventions

Accountable Lead Organization: North Simcoe Muskoka LHIN	Year 3 – (ST) 2013/14		Year 4 – (MT) 2014/15		Year 5 – (MT) 2015/16	
	Status	%	Status	%	Status	%
Recruitment Portal: Develop a recruitment portal linked to existing databases; identify gaps and technology requirements and permissions; and develop a marketing plan to develop a compelling branding.	Will complete	100				
Standardize Best Practices: Make recommendations on policies (e.g. HOOP benefit participation, mileage, access to SharePoint) and link with CCAC shared services collaboration	In progress	50	In progress	90	Will complete	100
Recruitment / Retention Strategy: Develop a LHIN-wide recruitment / retention strategy for health professionals, including common 'brand' and joint marketing/advertising initiatives to attract new talent into the region; and shared database of resource pool with shared applicant tracking system.	In progress	60	Will complete	100		
Accelerate Development: LHIN-wide learning and development strategies and programs; and common credentialing process.	In progress	50	In progress	40	Will complete	10
Enhanced Work Environment: Workforce mobility strategy and programs; and collaboration on employee programs.	In progress	40	In progress	30	Will complete	30
Optimize HR Service Delivery: Collaboration with labour unions and ministries to develop flexible arrangements and expand scope; knowledge sharing through repository of HR leading practices, tools, programs, policies and other useful information; HR shared services feasibility study/business case; and shared labour relations expertise.			In progress	75	Will complete	100

Risks / Barriers to Successful Implementation

- Involvement of hospitals in NSM LHIN with IHHR planning and being part of a system-wide effort to recruit, retain, plan and develop local talent in the health system
- Competitive environment for limited talent
- Diverse Human Resources Information Systems (HRIS); 'one source of truth' not available
- Variety of different staffing standards and skill mix by health services providers; may present a challenge when implementing new service models
- Variations to the feasibility of incorporating a standardized model at all sites to deliver care; in the event that clinical areas identify unique inpatient programs at certain sites, this may result in shifts in resourcing to align with patient profiles
- Variability among stakeholders as to the appropriate scope of responsibilities for unregulated staff in supporting professionals while meeting the holistic needs of patients
- Current funding models for physicians in some programs may not incent recruitment and retention; and Health System Funding Reform may impact the recruitment of physician specialties
- Siting and sizing of programs may be shift resourcing from one site to another, which may result in staffing changes or layoffs; involvement with labour unions will be critical in implementing evolving workforce and resourcing models.

Key Enablers

- Connection and linkage with other Care Connection Coordinating Councils to understand their needs and where overlap opportunity presents itself with HHR planning
- Senior Leadership and buy-in is required to ensure movement forward on the implementation of IHHR strategic directions deliverables.

System Navigation

Purpose / Goal(s)

To improve the experience of each patient/caregiver and helps ensure the right care at the right time in the right place. It includes information and knowledge sharing, assessment and the development of a shared plan of care, linkages to appropriate services or place of care and appropriate follow-up to ensure a safe referral or transition. All populations benefit.

System Aims

- Person-Centredness - To develop a comprehensive and current system-wide inventory of health and social services.
- Access - To develop a user-friendly and standardized referral system to match client / individual need to available resources.
- Safety - To develop LHIN-wide protocols to standardize client / individual transitions from one setting / sector to the next.

Alignment

- Ontario's Action Plan for Health Care
 - o Priority 2 – Faster access and a stronger link to family health care.
 - o Priority 3 – The right care, at the right time, in the right place.
- Ontario's Action Plan for Seniors
 - o Healthy Seniors - Improved access to primary and community care.

Through an integrated and systems approach all individuals, patients/caregivers and providers will have access to the most appropriate information and care in the location of their choice. Through safe and effective transitions, processes will include more timely access to supports and linkages with primary care.

Action Plans / Interventions

Accountable Lead Organization: North Simcoe Muskoka CCAC	Year 3 – (ST) 2013/14		Year 4 – (MT) 2014/15		Year 5 – (MT) 2015/16	
	Status	%	Status	%	Status	%
Integrated data set with Connex	In progress	25	In progress	75	Will complete	100
Process to ensure LHIN wide data inventory is maintained and updated as per AIRS standards	In progress	25	In progress	75	Will complete	100
Process to enable the inclusion of two additional mini sites/year in nsmhealthline as vehicles for access to relevant health information within the LHIN	In progress	25	In progress	75	Will complete	100
Develop a repository and define parameters for evidence based screening and assessment tools to facilitate use by health providers	In progress	25	In progress	50	Will complete	100

Design and implement a process to inventory and prioritize the System Navigation requirements of other Coordinating Councils, with emphasis on the requirements of key populations (Aboriginal, Francophone, Mental Health and Addictions)	In progress	25	Will complete	100		
Develop and implement a community engagement strategy and plan for System Navigation	In progress	50	Will complete	100		
Develop and implement a communication plan to educate on system navigation outcomes	In progress	25	In progress	50	Will complete	100
Implement CCAC Expanded Role (Assisted Living) and transition support nurses (Rapid Response Nurses, Mental Health and Addictions Nurses in schools and Palliative Nurse Practitioners)	In progress	50	Will complete	100		
Design and implement the processes required to share assessment information using the Integrated Assessment Record (IAR) to decrease assessment burden of clients and optimize use of healthcare resources	In progress	25	In progress	75	Will complete	100
Design and implement a process for electronic referral and a collaborative care model with community support services	In progress	25	In progress	50	Will complete	100
Plan and develop strategies to support transition safety including patient transportation/transfer protocols, discharge protocols, corridor of care agreements and repatriation agreements.			In progress	50	Will complete	100
Plan and develop protocols that align with and support the Health Link activities related to transitions			In progress	50	Will complete	100

Risks / Barriers to Successful Implementation

- Funding for subsequent mini site develop and maintenance may need to be found within current / planned health service provider, LHIN initiatives and/or MOHLTC resources
- Lack of compatible IT platforms
- Varied readiness of Coordinating Councils may result in phased System Navigation deployment
- Other priority deployments (e.g. RM&R) may alter the resources dedicated to System Navigation objectives.

Key Enablers

- Robust stakeholder engagement plan and communication plan
- Project management approach with clear deliverables and reasonable project scope
- Focused work plan for System Navigation Lead
- Key interfaces with other Coordinating Councils to determine expectations/readiness to proceed
- Understanding and involvement in key initiatives that are closely aligned/dependent on System Navigation strategies (e.g. Health Links).

Transportation

Purpose / Goal(s)

To identify transportation requirements and establish an integrated transportation system in alignment with alternative technologies and service delivery options to improve health outcomes and wellness services.

System Aims

- Access - To enable inter-facility transportation system that is user-friendly, standardized and time-sensitive.
- Safety - To provide a system that matches the transportation service to the clinical needs of the patient / individual.
- Efficiency - To provide a coordinated system that facilitates the optimal use of resources in patient / client movement.

Alignment

- Ontario's Action Plan for Health Care
 - Priority 2 – Faster access and a stronger link to family health care.
 - Priority 3 – The right care, at the right time, in the right place.

Action Plans / Interventions

Accountable Lead Organization: County of Simcoe	Year 3 – (ST) 2013/14		Year 4 – (MT) 2014/15		Year 5 – (MT) 2015/16	
	Status	%	Status	%	Status	%
Develop & implement a standardized inter-facility transportation brochure for clients	Will complete	100				
Finalize, pilot & implement clinical/transportation decision tree (inter-facility)	In Progress	25	Will complete	100		
Develop, pilot & implement a clinical/transportation decision tree (community)			Will complete	100		
Collaborate with 211 to create and update a registry (including costs) of transportation services for clients			Will complete	100		
Develop & implement a standardized communication/hand-off (client transfer form) between clients & transportation services	Will complete	100				
Explore centralization of services for transportation booking (to include online tracking & documentation)	In progress	50	Will complete	100		
Review & recommend to LHIN governance structure for accountability of inter-facility transportation services			Will complete	100		
Develop & implement a communications strategy to increase awareness, promote engagement & increase success in establishing an integrated transportation system	Will complete	100				

Risks / Barriers to Successful Implementation

- Transportation, as an enabler of health and wellness care, is a very broad and diversified area involving many stakeholders throughout the region. Ensuring effective communication, focus on a common goal, and comprehensive representation (for profit, municipal and not-for-profit) is a challenge
- The human resource requirements associated with this focus area are extensive and can be limiting if adequate resourcing is not available. The attainment of a coordinator position to assist with this initiative would provide great strength in achieving the goals set out by this group
- The implementation and success of some of the identified strategies may be dependent within the current / planned health service provider, LHIN and/or MOHLTC resources or initiatives.

Key Enablers

- Regulation of Non-urgent Transportation Services
- Collaboration with eHealth, System Navigation, transitions of care initiatives (e.g. resource matching & referral) and the development of Health Links across NSM
- Additional Human Resource support through the recruitment of a funded coordinator position to ensure effective planning, assist with research and workflow, ongoing progress monitoring and regular evaluation and future projection.

2.2 Success / Outcome Measures

Across the NSM LHIN, be it individually, organizationally or collectively, there is a desire to achieve high standards and to ensure the needs of communities are being met in the most effective way. As public stewards of the local health system, the NSM LHIN is committed to demonstrating outcomes and/or success through clear measures linked to its strategic direction and priorities. IHSP 2013 – 2016 builds upon the performance management approach introduced in IHSP 2010 – 2013; an approach predicated on 5 principles which guide the development of a core group of indicators, specific timelines and clear accountability.

All performance measurements should have coherent flows of logic from strategic areas of focus through to service-level performance measures and targets. In addition, and as demonstrated in Figure 2.2.1, the performance management approach at NSM LHIN aligns not only with the mission and vision but also three widely accepted approaches to demonstrating value and managing performance.

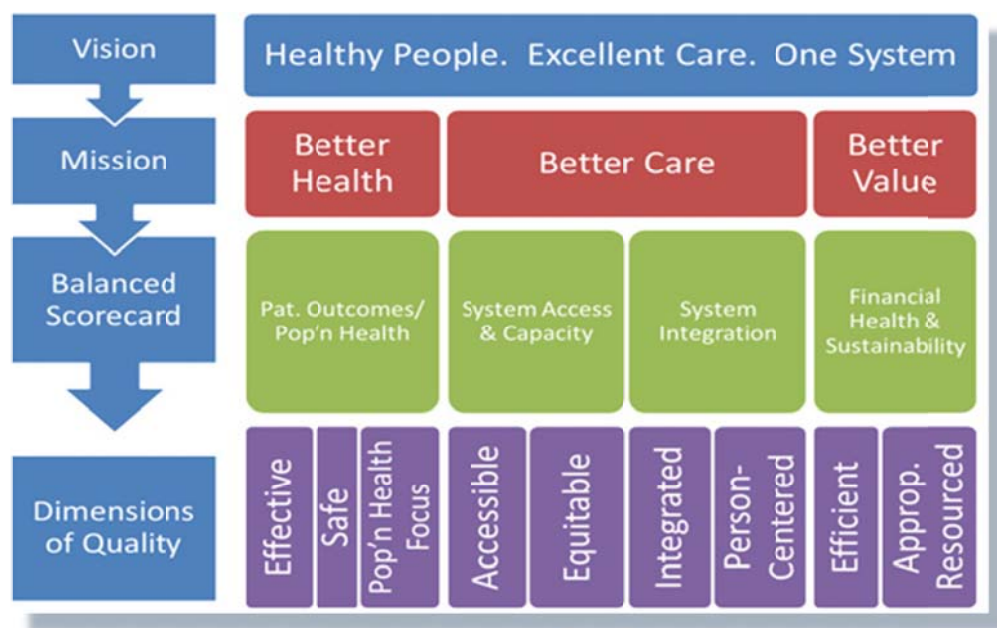


Figure 2.2.1 – *Care Connections* Performance Cascade

What follows in Figure 2.2.2 is a summary of the currently identified Performance Indicators requested from all twelve *Care Connections* Coordinating Councils under the *Care Connections* Performance Framework. It is intended as a Status Report of "work to date" on indicator development and not as a finalized list of Aims and Indicators.

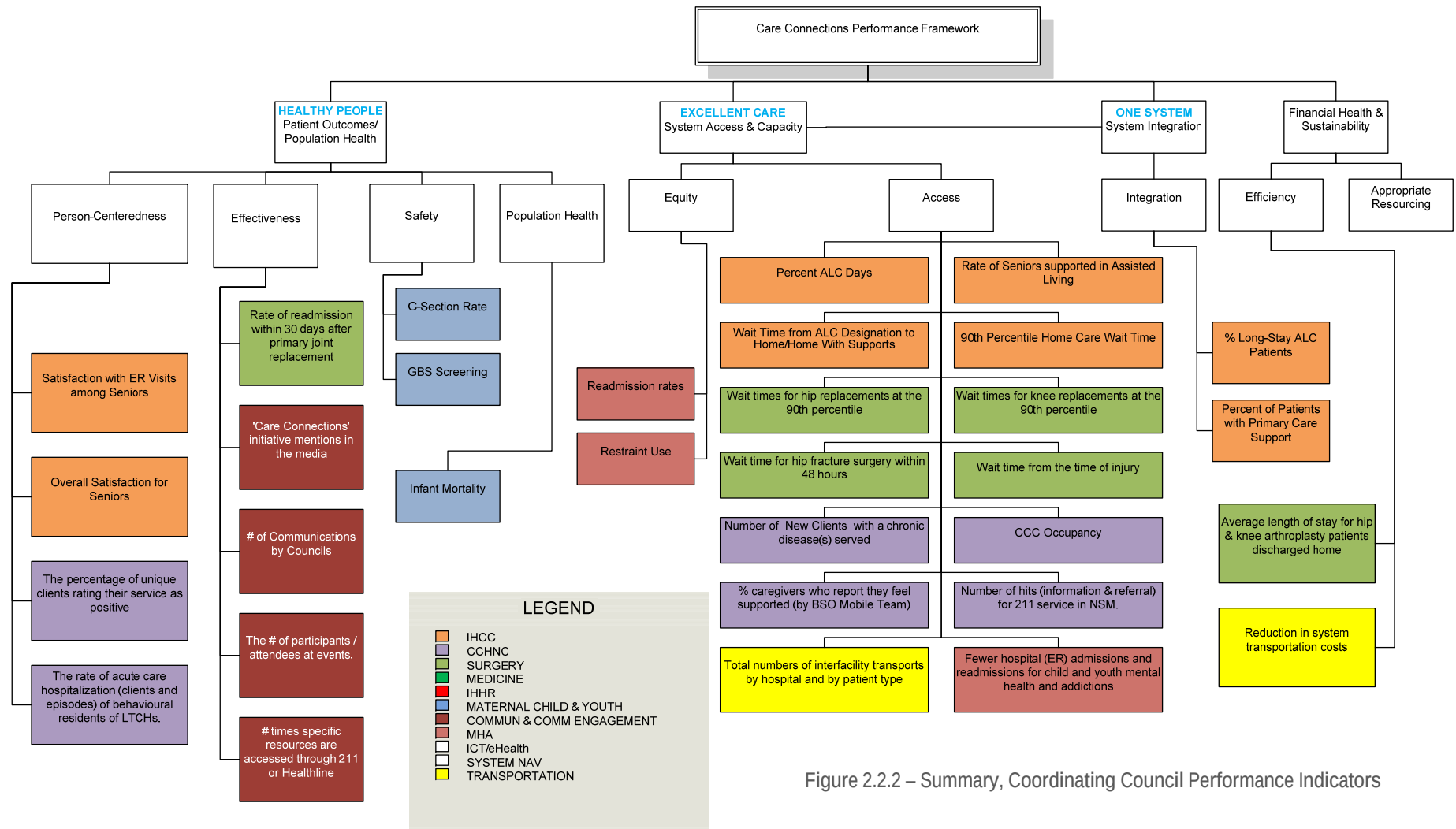


Figure 2.2.2 – Summary, Coordinating Council Performance Indicators

section 3 | LHIN financial plan: operations & staffing

LHIN Operations Spending Plan				
LHIN Operations Sub-Category (\$)	2012/13 Forecast (Dec)	2013/14 Allocation	2014/15 Planned Expenses	2015/16 Planned Expenses
Salaries and Wages	2,413,489	3,058,090	3,129,335	3,107,585
Employee Benefits				
HOOPP	214,182	297,640	304,270	302,154
Other Benefits	322,449	383,460	402,633	422,765
Total Employee Benefits	536,631	681,100	706,903	724,919
Transportation and Communication				
Staff Travel	67,579	95,800	80,000	80,000
Governance Travel	20,960	21,000	21,000	21,000
Communications	53,587	68,020	50,000	50,000
Other Benefits	39,514	10,000	10,000	10,000
Total Transportation and Communication	181,640	194,820	161,000	161,000
Services				
Accommodation (includes Insurance)	161,243	344,750	185,000	185,000
Advertising	-	-	-	-
Banking	60	-	-	-
Community Engagement	30,440	48,500	48,500	48,500
Consulting Fees	18,388	40,000	30,000	30,000
Equipment Rentals	9,040	12,000	12,000	12,000
Governance Per Diems	119,105	118,700	118,700	118,700
LSSO Shared Costs (includes LHINC)	389,140	411,650	411,650	411,650
Other Meeting Expenses	45,771	60,000	60,000	60,000
Other Governance Costs	16,172	18,720	18,720	18,720
Printing & Translation	15,961	22,500	22,500	22,500
Staff Development	108,282	82,500	40,000	40,000
Total Services	913,602	1,159,320	947,070	947,070
Supplies and Equipment				
IT Equipment	27,994	40,000	32,222	35,957
Office Supplies & Purchased Equipment	62,530	30,000	30,000	30,000
Total Supplies and Equipment	90,524	70,000	62,222	65,957
LHIN Operations: Total Planned Expense	4,135,886	5,163,330	5,006,530	5,006,530
Annual Funding Target	4,135,886	5,163,330	5,006,530	5,006,530
Variance	-	-	0	0

Note - Does include transfer of new Diabetes Regional Coordination Centre funds and does not include other funding (ER/ALC, FLS, Leads, BSO, PMO, FLHF)

Risk - 2014/2015 - Expected Salary increases and inflationary costs will need to be absorbed within budget

Risk - 2015/2016 - inflationary costs again, may require reduction of 1-2 FTE in order to balance with zero percent base increase in allocation

Risk - Accommodation expenses do not include entire lease costs as approx 20% are covered by ancillary funding sources

LHIN Staffing Plan (Full-Time Equivalents)				
Position Title	2012/13 Actuals as of April 1, 2013 FTEs	2013/14 Forecast FTEs	2014/15 Forecast FTEs	2015/16 Forecast FTEs
CEO	1	1	1	1
COO	1	1	1	1
Director	3	2	2	2
Senior Manager	5	5	5	5
Manager	1	1	1	1
Executive Coordinator	1	1	1	1
Senior Advisor	4	4	4	4
Executive Assistant	2	2	2	2
Comm Coordinator	1	1	1	1
Program Assistant	1	1	1	1
Advisor	4	5	5	4
Admin Assistant	3	3	3	3
CE Coordinator	1	1	1	1
Analyst	1	1	1	1
HR Coordinator	1	1	1	1
Executive Coach	0	0.4	0	0
Subtotal	30	30.4	30	29
FLS Coordinator	1	1	1	1
ER/ALC	0.8	0.8	0.8	0.8
PMO	3	4	4	4
Total FTEs	34.8	36.2	35.8	34.8
Note - 2015/16 reduced 1 FTE due to funding adjustment (Reflected in Planned Financial Forecast)				

section 4 | communications & community engagement plan

OBJECTIVES

Business Objectives

The strategic directions of the NSM LHIN's IHSP 2013 -2016, *Healthy People. Excellent Care. One System.* and the initiatives identified in ABP 2013 – 2014 require a strong communications strategy and plan. The communications strategy is critical to supporting the execution of the *Care Connections* health system transformation agenda as it is implemented across the LHIN.

The communication strategy and plan will continue to...

- Foster an understanding of the need for health system transformation both internally and externally
- Build support for the health system model by focusing on the benefits of the health system transformation that creates an integrated sustainable health care system that ensures better health, better care, better value for money
- Align the health service providers to the shared vision, mission, values and common *Healthy People. Excellent Care. One System.* direction of helping NSM LHIN residents spend more time in their homes and their communities
- Demonstrate how organizations and individuals can participate in the success of the health system transformation.
- Mitigate communications risks of negative publicity by proactive planning of risk reduction
- Provide information on performance and progress on the implementation – document successes and share it.

Communications Objectives

- Guide the communications and engagement activities of the NSM LHIN (Board and staff) and health service provider partners involved in initiatives contained in ABP 2013 – 2014
- Ensure all stakeholders understand the role of the respective organizations to identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services based on funding availability and tracking performance against signed accountability agreements
- Provide accurate and timely information to all audience
- Be transparent and accountable to our shared audiences re: timelines, outcomes and opportunity for participation/feedback.

CONTEXT

Ontario's Action Plan for Health Care, announced by the Minister in January 2012, which is consistent with the principles of the *Excellent Care for All Act* (2010), places Ontario's LHINs at the centre of health system transformation. As a result, LHINs have a critical role to play in key provincial initiatives recently introduced such as Health System Funding Reform, Health Links, Ontario's Seniors Strategy and the expansion of Quality Improvement Plans into the primary and community care sectors.

The health care system has evolved to the point where LHINs are being recognized as local system managers that play a central leadership role in driving health system transformation. IHSP 2013 – 2016 - *Healthy People. Excellent Care. One System.* and the initiatives laid out in ABP 2013 – 2014 are strategically aligned with government direction and priorities and recognize the joint accountability of the ministry and LHINs to serve the public interest and effectively oversee the use of public funds.

STAKEHOLDERS

Depending on the situation primary and secondary stakeholders / audiences will include...

- Health Service Providers across NSM and surrounding LHINs
 - Health Service Providers Leadership and Front Line staff (including union leadership)
 - Health Service Provider Boards

- Physicians
- Patients/Clients/Consumers/Residents
- Consumer/Patient Support Groups
- Healthcare Associations (OHA, ONA, OMA, etc.)
- Government
 - Municipal
 - Regional
 - Provincial: including Ministry of Health and Long-Term Care, other ministries as appropriate
 - Federal
- General Public
 - Residents
 - Community Organizations
- Media
- LHINs

STRATEGIC APPROACH

With the intent of promoting collaboration, engagement and information sharing to support NSM's IHSP 2013-2016 and ABP 2013-2014, a communications and community engagement plan will be developed by the *Care Connections* Communications and Community Engagement Coordinating Council.

The plan will document the context for each initiative, timelines, audiences, tools/tactics, specific key messages and a deliverables tracking chart. This document will be updated on a timely basis and shared with the LHIN Liaison Branch (LLB) and the MOHLTC's Communication and Information Branch (CIB), per the Communications Appendix attached to the "Memorandum of Understanding", MOU and approvals required by the Assistant Deputy Minister.

KEY MESSAGES

- The NSM LHIN is a key partner in transforming the health system to provide quality care that meets the needs of Ontarians today and into the future.
- We are changing from an old system designed to treat people once they are sick to a more coordinated, value-driven model that promotes wellness.
- Populations are growing and aging, and the rates of chronic conditions are rising.
- Current fiscal realities have resulted in even more challenges.
- NSM LHIN and our partners have already brought about significant and positive change in the way health services are delivered, and we must continue that work. In fact, we must aggressively build upon that work, because the status quo is neither acceptable nor sustainable.
- Everyone has an important role to play in making healthy change happen, including health-service providers, the LHINs, community leaders and the public.
- The NSM health system needs to be adaptable to the changing environment and fiscal realities.
 - By being open and receptive to new opportunities for the provision of care, we have the capability of ensuring our health care resources are used in a responsible manner achieving enhanced care for our residents
- NSM residents continue to be engaged and play an integral role in the development of the health care system.

- We are working with all health service partners to transition appropriate procedures out of high cost hospital settings into non-profit community based clinic.
- The NSM LHIN and our health service partners are taking into account the diversity and locations of the population in respect to what services need to be prioritized and where they should be delivered.
- The NSM LHIN is working together with all our health service providers, funded and non-funded, to provide care in the most appropriate setting.
 - What does this mean for you? It means getting the care you need, when you need it, in the most appropriate place and by the most appropriate provider.

TACTICS (high level, if available)

- To be referenced in each plan but will include...
 - News releases/Blast Emails/Newsletters/Bulletins/LHINfo Minutes
 - Website postings/alerts/social media
 - Stakeholder events
 - Outreach to local government stakeholders
 - Engagement with specific stakeholders – unions, provincial associations, community groups.

COMMUNITY ENGAGEMENT

Aboriginal Community

North Simcoe Muskoka is home to four First Nations. A variety of health services are provided by 12 separate Aboriginal Health Service Provider agencies. On September 1, 2010, an Aboriginal Health Circle was established and continues to meet with NSM Priority and Geographic Leads to identify and develop objectives and deliverables to meet the strategic priorities of the NSM LHIN's three year Integrated Health Services Plan (IHSP) 2013 – 2016.

Francophone Community

On December 15, 2010, the Ministry of Health & Long-Term Care named the Francophone planning entity for the North Simcoe Muskoka, Central and Central East LHINs. This newly formed organization, known as Entité de planification pour les services de santé en français #4 Centre Sud-Ouest / French language health planning entity #4 for Central South West Ontario, is incorporated as a non-profit organization with a board of directors comprised of residents from each of the LHINs. In 2013 – 2014, the NSM LHIN will continue to work closely with the planning entity to establish their working relationship, including roles and responsibilities in relation to engaging the Francophone community.

Health Service Providers

In 2013 – 2014, the NSM LHIN is responsible for:

- 1 Community Care Access Centre
- 3 Community Health Centres
- 9 Community Mental Health and Addictions Services
- 31 Community Support Services
- 7 Hospital Corporations (9 hospital sites)
- 26 Long Term Care Homes

In addition to funded service providers, the NSM LHIN is home to one public health unit, six family health teams, and one Nurse Practitioner Led Clinic. We consider these organizations to be an important part of the NSM LHIN health service provider community. Engagement of the health service provider community, its governors and health system partners is active and ongoing in NSM. Regular interaction on business activities such as performance reporting is key to the NSM LHIN's understanding of the local health system environment.

General Public

In an ongoing effort to keep our communities informed, the NSM LHIN will use its website (www.nsmhlin.on.ca) for regular posting of news and information of interest to our communities.

Notice of Public Consultations & Information Sessions

Notice of planned consultations as well as any project or consultation-related reading materials will be posted on the NSM LHIN website. The engagement process may vary depending on the project as the form of consultation must be designed to accommodate the informational needs of the project and the community to be consulted as well as the time and available project resources.

Deliverables

Date	Tactic/Event	Purpose
April 26, 2013	Value Stream Mapping – System Navigation	1. To develop a value statement that is the “voice of the customer” and serves as our “conscience” in future work; 2. To visualize the current client journey and identify the wastes in the system which have been addressed and ones remaining (this helps to communicate how we will free up the resources to allow for the change). 3. To draft a value stream map of the desired future state that includes information and referral and improves the client experience; 4. To identify the gaps between the current and future state, and create a high level action plan to define next steps.
May 28 & 29, 2013	Annual Forum (30 to 40 exhibitors/booths will share information on May 28 th and the 29 th will have plenary sessions for 310 local health care stakeholders/ partners)	1. The focus is on ‘transitions of care’ 2. Progress to date within Care Connections initiatives and next steps will be discussed/demonstrated by presenting local health care stakeholders and experts 3. The focus will be on clients and residents and continuing to build and provide the health care needed in North Simcoe Muskoka
June 2013	Board to Board Governance/ Education	The Care Connections Governance Council will conduct 5 education and discussion sessions re: governing in an integrated health care system
June 2013 to March 2014	Value Stream Mapping – Care Connections Councils	The remaining 11 Care Connections Councils and their partners and stakeholders will each conduct 2-day sessions (see objectives from April 26, 2013 event above).
May 2013 January 2014	Annual Aboriginal Health Forum and Value Stream Mapping for the Aboriginal Health Link	Local experts and stakeholders from within North Simcoe Muskoka's Aboriginal communities as well as partners in health care across our region will be engaged to discuss how to better work with and serve our Aboriginal residents.
September 2013	People with Lived Experience/Clients/ Patients	Empowering Individuals to Successful Healthcare – we will partner again with Patient Destiny to help our clients and residents become more informed and pro-active with regards to their own health care.

September 2013	Stakeholder Engagement re: Chronic Disease/ Diabetes	Local health care experts and primary care providers (including 6 physician leads) will continue to meet regarding chronic disease prevention and management in our local health care system.
November 2013	NSM Fall Conference re: Chronic Disease Prevention & Management	This conference brings together 120+ NSM stakeholders (RNs, RDs, Physicians, etc.) re: Primary Care and Chronic Disease. National and international experts are brought in to speak at this CME accredited event.
September 2013 January 2014 June 2014	Regional Meetings - Building Community Capacity and Resilience	Meetings/discussions will continue to be held in each of North Simcoe Muskoka's 5 geographic regions of the LHIN to discuss, plan, activate and maintain local community capacity.
October 2013	Value Stream Mapping for the Francophone Health Link	Local experts and stakeholders from within North Simcoe Muskoka's Francophone communities as well as partners in health care across our region will be engaged to discuss how to better work with and serve our Francophone residents.

EVALUATION

Identifying and tracking critical communication success factors will enable the NSM LHIN to more effectively identify whether communication activities have been successful. Critical success factors may include...

- Visible senior leadership engagement and support of the ABP initiatives and related communications
- Senior leadership and LHIN-wide committees take visible, active roles in supporting communications and change with their teams.
- Key stakeholders have a clear understanding of the *Care Connections* transformation agenda and how they will be impacted by the implementation of any related initiatives
- Health service providers across the NSM LHIN are engaged early and frequently and can see how their participation is impacting implementation
- NSM LHIN residents are engaged by the LHIN and with the LHIN via a variety of tactics including traditional media, online/social media (e.g. websites, Twitter) and LHIN communication vehicles (blast emails, bulletins)
- Feedback mechanisms and ongoing assessment are in place to monitor the effectiveness of communication vehicles and messages and the LHIN has the ability to make quick modifications based on shifts and lessons learned as activities are carried out.

section 5 | conclusion

IHSP 2013 – 2016 and, by extension, ABP 2013 – 2014 have evolved from a simple but critically important premise: that residents and health system partners alike share a common belief in both the importance of the health system and its responsiveness to the needs of local communities. Aligned with ministerial priorities and pan-LHIN system imperatives, these plans have adopted the NSM LHIN's vision, its *Care Connections* framework and inspirational values. As a result, long-term sustainable change, that is to say a new way of thinking, acting and behaving, will be attained.

The health system in NSM has much to celebrate. The resilience and capacity of health system partners at the system-wide and local levels to deal with and effectively manage change through continuous improvement, is a foundation upon which future change and opportunities will be based.

The reality of health system partners taking ownership, accepting accountability and managing transformation across the NSM LHIN cannot be understated and, as a result, by remaining focused and committed to a common vision, they can continue to enhance the health of NSM's population through better health, better care and better value.

The NSM LHIN landscape is changing and there is still much to be done. Ontario's population is aging; more so across NSM. As people age, they require more health care; more often than not, more complex health care. With the complexity of the residents' health needs increasing, so too must the capacity and efficiencies of service and program delivery be enhanced in order to provide quality care that is accessible and safe within community, in a manner that is integrated and appropriately resourced within the local health system. This ever-changing landscape and environment requires a nimble and adaptable local health system that is ready to embrace change in order to support its mission, vision and values especially as they relate to primary care and the building of healthy communities.

Through ABP 2013 – 2014 and *Care Connections*, there are many new and exciting opportunities to be realized both through the coming year and beyond; the likes of which are only just now beginning to align with and support health system transformation across the NSM LHIN.

In support of IHSP 2013 – 2016 and its focus on holding the gains, ABP 2012 – 2013 helps NSM stay the course through a renewed affirmation of basic tenets including a collective will to change, a focus on what can be controlled, careful attention to the changing landscape, open and honest dialogue, the courage to take risk, an awareness of organizational readiness and capacity, and a realization that our relationships are very much interdependent. All in continued pursuit of...

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