



2016-2017

Annual Business Plan

June 24, 2016

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Introduction

A new perspective and fresh approach began with the North Simcoe Muskoka Local Health Integration Network's (NSM LHIN's) Integrated Health Service Plan (IHSP) for 2016-2019. As required by the provincial Agencies and Appointments Directive, the NSM LHIN has developed its Annual Business Plan (ABP) for 2016/17. The ABP serves as the operational plan for the LHIN to deliver upon the first year of the IHSP.

The NSM LHIN 2016/17 Annual Business Plan continues to build on past successes. The health care system is transforming and the work to be completed in the upcoming year reflects this continuous evolution. In creating the 2016/17 ABP, the NSM LHIN has embarked on another annual planning cycle. During this planning, subject matter expertise has been leveraged to ensure the correct policies, levers and actions are employed to enable the LHIN to meet strategic priorities. These strategic priorities as outlined in the 2016-2019 IHSP are as follows:

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

These three priorities were developed in alignment with the Ministry of Health and Long-Term Care's *Patients First: Action Plan for Health Care*.¹ The needs of the local population and feedback from key stakeholders including patients and health service providers, ultimately shaped the North Simcoe Muskoka LHIN's strategic priorities and goals as set by the NSM LHIN Board of Directors.

The following Annual Business Plan takes the IHSP priorities and presents the work to be done at the operational level for the upcoming year. For each strategic priority, greater detail has been provided beyond that of the IHSP regarding the specific goals for the year and the actions to be taken by the LHIN to support these goals. Each goal has been aligned with actions and indicators of success that will be measured to ensure LHIN accountability for the 2016/17 deliverables. LHIN transparency and accountability is of prime importance and a core element of the *Patients First: Action Plan for Health Care*.¹ The LHIN's role is to plan, fund, integrate and evaluate the health services across the region to ensure that health outcomes are optimized and the health care system remains sustainable for the future. The development and monitoring of the Annual Business Plan is key to transparency for stakeholders and LHIN accountability for deliverables. It is within this framework that the 2016/17 NSM LHIN Annual Business Plan is presented to enable the NSM LHIN to deliver its vision of **Healthy people. Excellent care. One system.**

¹ Office of the Minister, Ministry of Health and Long-Term Care. Patients first: action plan for health care. Ministry of Health and Long-Term Care; 2015.

Setting Context

NSM LHIN Mandate and Strategic Directions

The current vision, mission, and values of the North Simcoe Muskoka LHIN were established in 2010. During the IHSP strategic planning over the last year and the annual operational planning for 2016/17, the vision, mission, and values have been affirmed by LHIN stakeholders and leadership.

The vision: **Healthy people. Excellent care. One system.** remains the foundation for all work dedicated to health system improvement.

The mission: **Together....Achieving Better Health, Better Care, Better Value** speaks to the collaboration required to optimize outcomes and realize value.

The NSM LHIN values continue embody the approach to innovation and health system transformation:

- Be Real: Engage with Purpose
- Be Revolutionary: Explore the Possibilities
- Be Courageous: Model the Way

The Ministry of Health and Long-Term Care's *Patients First: Action Plan for Health Care* is the next phase of Ontario's plan for changing and improving the health system.² The Ministry of Health and Long-Term Care (MOHLTC) has identified four key objectives that will be the foundation for initiatives to be pursued in the upcoming years of the current provincial mandate. These four priority areas build on the progress made under the Excellent Care for All Act,³ (ECFAA). Accordingly, the North Simcoe Muskoka LHIN has aligned its 2016-2019 IHSP strategic priorities to the goals identified in the Action Plan. The strategic priorities and areas of focus for the NSM LHIN are as follows:

NSM LHIN Strategic Priorities	IMPROVE ACCESS TO APPROPRIATE CARE	BUILD CAPACITY AND ENHANCE COORDINATION	DRIVE SYSTEM SUSTAINABILITY
NSM LHIN Areas of Focus	▪ Seniors Services ▪ Primary Care ▪ Health Links ▪ Home and Community Care ▪ Long-Term Care Redevelopment ▪ End-of-Life / Palliative Care ▪ Mental Health and Addiction Services		

It is within this framework that the specific rationale, actions, deliverables and indicators included within the 2016/17 Annual Business Plan will be described. The NSM LHIN aligns its operational work with the Action Plan of the MOHLTC in addition to other provincial directives, policies, and initiatives. These linkages will be demonstrated throughout the ABP document.

² Office of the Minister, Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Ministry of Health and Long-Term Care; 2015.

³ Ontario, *Excellent Care for All Act*, 2010, S.O. 2010, c. 14

LHIN Funded Service Providers in North Simcoe Muskoka

In 2016/17, the North Simcoe Muskoka LHIN will be responsible for allocating over 850 million in funding to 71 LHIN funded health service provider organizations delivering services across the continuum of care. There are currently eight health service providers that are identified and one that is designated to provide health care services in French within the region. The LHIN also funds a variety of services through six organizations specifically serving the First Nations, Métis, and Inuit (FNMI) population.

HOSPITALS

- Beechwood Private Hospital
- Collingwood General and Marine Hospital
- Muskoka Algonquin Healthcare
- Georgian Bay General Hospital
- Orillia Soldiers' Memorial Hospital
- Royal Victoria Regional Health Centre
- Waypoint Centre for Mental Health Care

COMMUNITY HEALTH CENTRES

- Barrie Community Health Centre
- Centre de santé Communautaire Chigamik CHC Inc.
- South Georgian Bay Community Health Centre, The

LONG-TERM CARE HOMES

- Bay Haven Nursing Home Inc.
- Collingwood Nursing Home Ltd.
- Corporation of the County of Simcoe - Georgian Manor
- Corporation of the County of Simcoe - Sunset Manor Home for Senior Citizens
- Corporation of the County of Simcoe - Trillium Manor Homes for the Aged
- District Municipality of Muskoka (The Pines)
- Grove Park Home for Senior Citizens
- Hillcrest Village Inc. (Swiss Nursing Homes Inc.)
- Huntsville District Nursing Home Inc. (Fairvern)
- Huntsville Long-Term Care Inc. (Muskoka Landing in Huntsville)
- IOOF Seniors Homes Inc. - Odd Fellow & Rebekah
- Leacock Care Centre (Orillia)
- Mill Creek Care Centre
- Ontario Mission of the Deaf Incorporated, The
- Revera Long-Term Care - Oak Terrace
- Revera Long-Term Care - Sara Vista Nursing Centre
- Roberta Place (Barrie Long-Term Care Centre Inc.)
- Schlegel Villages Inc. - Coleman Care Centre
- Sienna Senior Living - Creedan Valley Care Community
- Sienna Senior Living - Muskoka Shores Care Community
- Sienna Senior Living - Owen Hill Care Community
- Spencer House Inc. (Sienna Senior Living managed) - Orillia
- Stayner Nursing Home Limited.
- Victoria Village Inc. (Victoria Village Manor)
- Villa Care Centre (Villa Homes Corporation)
- Woods Park Care Centre

COMMUNITY CARE ACCESS CENTRES

- North Simcoe Muskoka Community Care Access Centre

COMMUNITY SUPPORT SERVICES

- Alzheimer Society of Muskoka
- Alzheimer Society of Simcoe County
- Barrie Area Native Advisory Circle
- Beausoleil First Nation
- Brain Injury Services Muskoka-Simcoe
- Breaking Down Barriers-An Independent Living Centre Inc.
- Canadian National Institute for the Blind, The - Simcoe Branch
- Canadian Red Cross Society, The - Muskoka Branch
- Canadian Red Cross Society, The - Northumberland
- Canadian Red Cross Society, The - Simcoe County Branch
- Chippewas of Rama First Nation
- Corporation of the County of Simcoe – Georgian Day Out and Assisted Living
- Deaf Access Simcoe
- Gravenhurst Senior Citizens Club
- Grove Park Home for Senior Citizens
- Helping Hands, Orillia
- Hospice Georgian Triangle
- Hospice Huronia
- Hospice Simcoe
- Huntsville Meals on Wheels Inc.
- Independent Living Services of Simcoe County and Area
- Moose Deer Point First Nation
- Muskoka Seniors Home Assistance
- North Simcoe Muskoka Hospice Palliative Care Network
- Victorian Order of Nurses for Canada - Ontario Branch, Simcoe County
- Wahta Mohawks

COMMUNITY MENTAL HEALTH

- Canadian Mental Health Association, Simcoe County Branch
- Canadian Mental Health Association, Muskoka - Parry Sound Branch
- Enaahitig Healing Lodge and Learning Centre
- Huronia Transition Homes
- Mental Health Consumer Survivor Project of Simcoe County
- Seven South Street Treatment Centre
- Wendat Community Programs

Key Issues

Like all areas of the province, the NSM LHIN has a number of local issues that impact the planning and delivery of health services. While many of these are trends that are reflected across the province, others are specific to the unique characteristics of the NSM LHIN population.

Access to Appropriate Levels of Care

Local data indicates that individuals in North Simcoe Muskoka are not always accessing care that is appropriate for their needs. Despite having the third highest primary care attachment rate in the province, both the percentage of emergency department (ED) visits for less urgent / non-urgent conditions (43.4%) and the rate of ED visits that could have been better treated in a primary care setting (30.2/1000 population) exceed those of the province.⁴ Emergency visit rates are an indicator of the degree to which other parts of the system may not be meeting patient needs and timely access to primary care is required to ensure patients receive care in the most appropriate setting.

Data also shows that patients frequently remain in hospital while awaiting placement in a more appropriate setting, which is reflected in the alternate level of care (ALC) rate. The ALC rate represents the proportion of inpatient days in acute and post-acute care settings that are spent as ALC. In North Simcoe Muskoka, the proportion of patients designated ALC who are occupying acute care beds (16.6%) is consistently among the highest in the province.⁵ ALC patients who remain in hospital awaiting home and community services are at increased risk of deteriorating, which may necessitate long-term care placement.⁶ Currently, the largest proportion of ALC days were spent waiting for long-term care, where the median wait time was 199 days for patients waiting in acute care beds. Further to this, seniors aged 65 and older represent 87% of local acute care patients designated as ALC.⁵ This is of particular importance given the projected growth rate for the seniors population in NSM.

Aging Population

North Simcoe Muskoka currently ranks in the top three LHINs in terms of its relative proportion of seniors aged 65 and older. In 2015, seniors represented 18.8% of the NSM population. As is the case in other regions across the province, forecasted growth for seniors greatly exceeds that of other age groups. By 2020, seniors are expected to comprise 21.3% of the NSM population and by 2025 this will increase to 24.3%.⁷

Data from the Canadian Institute for Health Information (CIHI) shows that seniors are high users of the health care system, including the hospital, continuing care, home care, and primary care sectors.⁸ In 2012, the province began to explore the health care consumption and costs of high users. Using 2009/10 data, the Ministry of Health and Long-Term Care found that seniors aged 65 and older accounted for nearly 60% of the top 5% of cost-consuming users of hospital and home care services.⁹ Provincial data also shows a clear association between older age and the rates of both scheduled and unscheduled emergency department (ED) visits and ED visits for potentially preventable conditions.¹⁰ Between 2010 and 2012, seniors accounted for approximately 22.4% of all NSM Emergency Department visits.¹¹ Further to this, seniors aged 65 and older represent approximately 87% of NSM acute care patients designated as ALC.¹²

⁴ Health Analytics Branch. Environmental scan integrated health service plans 2016-19. Ministry of Health and Long-Term Care; 2015.

⁵ Access to Care. North Simcoe Muskoka LHIN monthly alternate level of care performance summary, December 2015. Cancer Care Ontario; 2015.

⁶ Health Quality Ontario. Quality monitor: 2012 report on Ontario's health system. Queen's Printer of Ontario; 2012.

⁷ Health Analytics Branch. Environmental scan integrated health service plans 2016-19. Ministry of Health and Long-Term Care; 2015

⁸ Canadian Institute for Health Information. Health care in Canada 2011 – A focus on seniors and aging. CIHI; 2011.

⁹ Rais S, Nazerian A, Ardal S, Chechulin Y, Bains N, Malikov K. High-cost users of Ontario's healthcare services. Healthcare Policy. 2013; 9(1): 44-51.

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

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

¹² Access to Care. North Simcoe Muskoka LHIN monthly alternate level of care performance summary, December 2015. Cancer Care Ontario; 2015.

Complexity and Chronic Disease Prevalence

In 2013, 43.5% of North Simcoe Muskoka residents aged 12 and older suffered from a chronic condition. This rate exceeds the provincial average and is the second highest rate among the 14 LHINs. Related to this are high rates of health system utilization and increased rates of mortality. Residents of this region had higher rates of both hospitalization and mortality from cancer, COPD, diabetes, ischemic heart disease, and stroke than the provincial average. Further, nine chronic conditions account for more than 60% of all deaths and nearly a quarter of all acute hospitalizations among NSM residents. High blood pressure is the most prevalent chronic condition in North Simcoe Muskoka, followed by arthritis and asthma.¹³

For the purposes of Health Links, the MOHLTC defined complex and chronic patients as those having three or more chronic conditions such as heart disease, diabetes, hypertension, and mental health conditions, among others. Nearly 2.0% of the NSM population is considered complex and chronic under this definition. While almost one-third of these patients reside in the Barrie area, the Orillia area has the highest prevalence, with 280 people per 10,000 identified and chronic and complex. Three NSM communities have more than 200 people per 10,000 identified as chronic and complex, specifically Orillia and area, Muskoka, and Midland/ Penetanguishene and area.¹⁴

Based on internal analyses, the largest proportion of chronic and complex patients in NSM are those between the ages of 75 and 84 years of age for both sexes. However, the prevalence of chronic and complex conditions begins to increase after the age of 55 years for both males and females. Among chronic and complex patients in NSM, the top five most prevalent conditions are hypertension, diabetes, ischemic heart disease, arthritis disorders, and pneumonia.¹⁴ Some of these conditions are preventable, and others are treatable conditions that could benefit from early intervention.

The NSM LHIN service area is home to four First Nations communities. This is of particular importance as it relates to chronic disease, as the rates for most chronic conditions are higher among First Nations people. In a 2010 Statistics Canada report, the prevalence of diagnosed chronic conditions for 2006/07 was significantly higher among First Nations as compared to non-aboriginal Canadians for 8 of 9 common conditions.¹⁵ Data also shows that rates of chronic disease are higher among the francophone population as compared to the general population in NSM.¹⁶ Addressing these and other disparities will be key in ensuring health equity for the region's diverse populations.

In Ontario, 30% of all individuals over the age of 15 will experience a mental health or a substance abuse problem in their lifetime.¹⁷ Data from acute care hospitalizations in North Simcoe Muskoka shows that the most frequent primary diagnoses at hospital discharge for conditions related to mental health and addiction are: mood disorders (45.8%), schizophrenia and other psychotic disorders (18.4%), and substance related disorders (15.3%).¹⁸

Emergency department visits among individuals with issues related to mental health and addiction continues to be a key issue locally. Data shows an increase in mental health and addiction related ED visits among NSM residents from 2010/11 to 2013/14. Specifically, the number of visits with a mental health or substance abuse (MH/SA) main problem diagnosis increased by 35.6% and the number of visits with a MH/SA condition in any diagnostic field increased by 32.4%. Mental Health Walk-In Clinics have recently been implemented in several locations through the region and it is anticipated that this initiative will have a direct impact on emergency department utilization by providing a more appropriate access point for those seeking mental health and addiction services.

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

¹⁴ Internal analysis based on 2013-14 data from the Discharge Abstracts Database (DAD), the National Ambulatory Care Reporting System (NACRS) and Ontario Mental Health Reporting System (OMHRS). Accessed via IntelliHealth, January 2015.

¹⁵ Garner R, Carrière G, Sanmartin C and the Longitudinal Health and Administrative Data Research Team. The health of Inuit, Métis, and First Nations adults living off-reserve in Canada: the impact of socio-economic status on inequalities in health. Statistics Canada; 2010.

¹⁶ Ministry of Health and Long-Term Care, Health Analytics Branch. Canadian community health survey (2005 and 2007): health outcomes, risk factors and preventative care for Francophone and Non-Francophones. Ministry of Health and Long-Term Care; 2009.

¹⁷ Ministry of Health and Long-Term Care. News release: Ontario investing \$28 million in mental health and addictions services. Queen's Printer for Ontario; 2015.

¹⁸ Internal analysis based on 2014 data from the Discharge Abstracts Database (DAD). Accessed via IntelliHealth, September 2015.

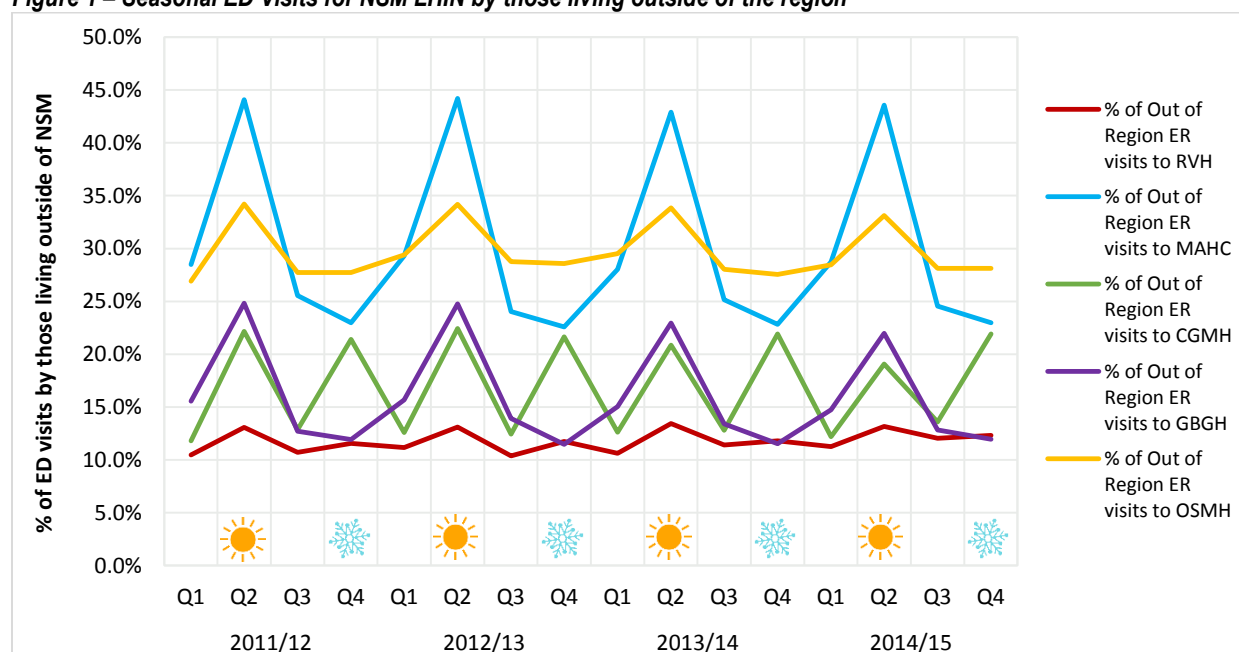
Utilization rates for designated mental health beds among NSM residents are among the highest in the province. Specifically, the rates of active cases, admissions and discharges per 100,000 population among NSM residents were the second highest among the 14 LHINs. Among active cases in NSM LHIN hospitals, short stay, mood disorders, and schizophrenia and psychotic disorders accounted for the largest proportions of patients.

Rural Geography and Seasonal Variability

Nearly one-third (32%) of NSM residents live in a rural area, making the region home to the third largest proportion of rural residents in the province. The region's large rural population is notable given that findings from a pan-Canadian study of rural health show a significant urban-rural gap on a number of health-related measures, including both risk factors like obesity and smoking, and outcomes, such as mortality from injury and certain chronic diseases.¹⁹

Given its location in and around cottage country, North Simcoe Muskoka experiences significant seasonal variation in population and demand for related health services. Seasonal population growth significantly impacts NSM emergency departments due to the requirement for health services by patients who are not rostered with local physicians. Significant utilization of emergency services by individuals who reside outside of the NSM service area is evident in the region's acute care facilities (See Figure 1 below). North Simcoe Muskoka is also an increasingly popular retirement destination. Given the increased health needs of the seniors population, this impacts utilization of health services across sectors, including acute care, home and community care, and long-term care.

Figure 1 – Seasonal ED Visits for NSM LHIN by those living outside of the region



¹⁹ DesMeules M, Pong R, Lagacé C, Heng D, Manuel D, Pitblado R et al. How healthy are rural Canadians? An assessment of their health status and health determinants. Canadian Institute for Health Information; 2006.

Financial Imperative

The provincial health care system continues to face unprecedented challenges precipitating the need to reduce the historical growth of health care expenditures. Health care spending currently accounts for approximately 42% of the provincial budget.²⁰ Historic levels of investment growth are not considered to be sustainable. Without a change in course, health care expenditures are projected to account for 70% of the provincial budget within twelve years.²⁰ There are considerable budget pressures for all health care providers across the province. Avoidable admissions and emergency department visits are expected to decrease by improving clinicians' access to timely information across all sectors.

Financial and statistical data indicates that in 2014/15, NSM's five community hospitals utilized 439 million of LHIN funding to service 256,256 patient days across 788 average beds staffed and in operation. In the same period, the specialty psychiatry facility in the region utilized 112 million of LHIN funding to service 101,315 patient days across 301 average beds staffed and in operation. The combined occupancy rate in NSM LHIN hospitals was 90% for fiscal 2014/15. Consistent with the fiscal climate across the province, it is expected that without significant change in the way services are delivered, there will be a considerable gap between the funding received and the health services provided in NSM by 2018/19. This gap creates a financial imperative that necessitates sustainability as a key strategic priority for the region.

Contributing to this challenge is the shift in demographics towards an increasing seniors population, which will result in higher costs to the system. Specifically, the cost of care for a senior is three times higher than that of the general population.²⁰ Ontarians are living longer and the baby boomers are now reaching an age where they will require more health care.²¹ It is therefore necessary to utilize health care resources in the most efficient manner to ensure that NSM residents continue to receive appropriate care in the future.

²⁰ Ministry of Health and Long-Term Care. Health system transformation: a year in review. Presented at Ontario Hospital Association Health Care Financial Management Conference; 2015.

²¹ Ministry of Health and Long-Term Care. Health system funding reform update. Presented at Ontario Hospital Association Health Care Financial Management Conference; 2015.

Drivers of System Change

As identified, there are a number of local issues that impact the planning and delivery of health services. In North Simcoe Muskoka these have been described as access to appropriate levels of care, the aging population, the prevalence of chronic conditions, geography and seasonal variability, and the financial imperative for change. These are some of the issues that are natural drivers of change at the local level. The work of the LHIN is also driven and influenced by provincial policy and direction and as such, annual planning must align with these evolving provincial priorities. Provincial direction, stakeholder feedback, and community engagement all drive system change and continuous improvement at the local level.

Primary Care Reform

The North Simcoe Muskoka LHIN has been working to better integrate care for a number of years now. The Family Health Teams within the LHIN region are cohesive and aligned by geography. NSM is one of only two LHINs to have a full-time physician on staff to support clinical planning and system integration. This role ensures that current activities and future plans are informed by clinical input. Further, through the NSM LHIN Primary Care Network, the LHIN has increased involvement and strengthened relationships with local primary care physicians, specialist physicians, and nurse practitioners.

Over the last decade, significant change in primary care has taken place in Ontario. The creation of new models of care, changes to contracts and funding reforms have resulted in fewer unattached patients. Despite substantial investment and change, significant challenges still exist. At times, care remains fragmented. Opportunities continue to exist to improve access, standardization, and oversight within primary care. While there are fewer unattached patients, timely access to primary care continues to be a challenge. Ontario's overall ranking relative to international comparators for primary care indicators is increasingly lagging despite significant change over recent years.²²

The Auditor General of Ontario's *2015 Annual Report*, identified the need for the Ministry of Health and Long-Term Care to determine how best the LHINs can support primary care to meet the mandate of system integration.²³ In particular, this is tied to LHIN performance on emergency department length of stay indicators, which are impacted by patient access to same day/next day and after-hours primary care. The MOHLTC responded by proposing to strengthen the LHIN role in planning and monitoring primary care services to support the province's vision for an integrated system. This strengthened role would be a key driver in determining the direction of LHIN work moving forward.

Transformation of Home and Community Care

In 2014, the Ontario government approved regulatory changes that enabled the LHINs to fund designated approved agencies in the community services sector to deliver personal support services. The policy guidelines that accompany this amendment outline expectations for the Community Care Access Centres and community service agencies to function as "one sector" with common standards and expectations for a consistent client experience. Regional implementation and strategies will focus on access, assessment, delivery and coordination of services in alignment with the provincial policy. Implementation of the policy guidelines will be phased, with the NSM LHIN moving forward in "Wave 3." Wave 3 is expected to start in April for planning, with the first clients expected through the new integration by October of 2016. It is anticipated that these changes will increase standardization of care, enhance relationships between providers, and improve the patient/client experience.

²² Steering Committee for the Ontario Primary Care Performance Measurement Initiative. A primary care performance measurement framework for Ontario. Report of the steering committee for the Ontario primary care performance measurement initiative: phase one. Health Quality Ontario; 2015.

²³ Auditor General of Ontario. Annual report 2015. Office of the Auditor General of Ontario; 2015.

In March 2015, the *Report of the Expert Group on Home and Community Care, Bringing Care Home* identified service challenges in home and community care across the province.²⁴ This work informed the development of the MOHLTC's *Roadmap to Strengthen Home and Community Care*, which outlined a plan to improve quality, consistency, and integration in the home and community care sector.²⁵ In September, 2015, the Auditor General of Ontario released a *Special Report on the Community Care Access Centres*, calling for reform in the way that services are delivered and organized within the CCACs.²⁶ The MOHLTC endorsed the report, accepting all sixteen recommendations that largely called for greater standardization of care across the province, increased accountability, and improved cost effectiveness with particular attention to CEO compensation, administrative fees, and direct nursing programs. This was followed by the Auditor General's *2015 Annual Report*, in which geographic inequities in the availability of personal support services and caregiver supports, inconsistencies in care coordination, and a lack of oversight of contracted service providers were identified.²⁷

The MOHLTC confirmed that the Auditor General's recommendations were aligned with the *Roadmap to Strengthen Home and Community Care* and has proposed system changes to ensure more consistent and accessible home and community care.²⁵ Specifically, the proposed changes call for a transfer of responsibility for service management and delivery from the Community Care Access Centres to the LHINs and for greater accountability and integration in home and community care. If approved, these proposed changes will significantly impact the LHIN scope and mandate and as such will provide significant opportunities to strengthen collaboration and integration of service providers, increase equity and system efficiency.

Health Links

Health Links were initiated at the provincial level for the purpose of better coordinating and integrating care for patients with complex and chronic health needs. This provincial initiative was then tailored and implemented at the community level. As identified by the Ministry of Health and Long-Term Care, Health Links will play an instrumental role going forward in delivering on the *Patients First: Action Plan for Health Care*.²⁸ The next step being taken at the provincial level is to standardize the model where appropriate, while recognizing local innovations. In June 2015, the MOHLTC introduced the Advanced Health Links Model, which was informed by both formal evaluation and ongoing reporting by the Health Links. This model includes changes in four key areas including standardization, performance management and oversight, funding model redesign, and wider system integration. The key aim of these changes is to allow the Health Links to build on successes to date and evolve to a more mature state of operation.

Health Links have been operational in North Simcoe Muskoka since 2014. The LHIN has demonstrated a commitment to equity by ensuring that Health Links were initiated and approved for each of the region's five communities. Full coverage across the region ensures that the NSM LHIN's most complex patients all have local access to coordinated care planning. Work at the provincial level continues to drive new thinking on sub-regional planning and governance across sectors for the collective benefit of all patients within a geography. Health Links thus far have demonstrated that sub-regional coordination across organizations is a good model and strong foundation for future work. Lessons learned locally and a provincial focus on integration will continue to drive LHIN work towards sub-regional integration in terms of oversight, technical integration and clinical collaboration. The MOHLTC has also identified a role for the Health Links as key supports to initiatives aimed at improving quality of care through their role in broader system integration. Health Links successes and lessons learned will inform and drive the evolution of other work in primary care, home and community, acute care, and chronic disease.

The Advanced Health Links Model will also support greater consistency by standardizing key elements across the province, including a common approach to patient identification and a formal process for identifying and spreading

²⁴ Donner G, Fooks C, McReynolds J, Sinha S, Smith K, Thomson D. Report of the expert group on home and community care, bringing home care. Expert Group on Home and Community Care; 2015.

²⁵ Ministry of Health and Long-Term Care. Patients first: A roadmap to strengthen home and community care. Office of the Minister, Ministry of Health and Long-Term Care; 2015.

²⁶ Auditor General of Ontario. Special report on Community Care Access Centres: Financial operations and service delivery. Office of the Auditor General of Ontario; 2015.

²⁷ Auditor General of Ontario. Annual report 2015. Office of the Auditor General of Ontario; 2015.

²⁸ Office of the Minister, Ministry of Health and Long-Term Care. Patients first: action plan for health care. Ministry of Health and Long-Term Care; 2015.

best practices. Defining the populations of patients who will receive maximum benefit from coordinated care planning in a standardized way has highlighted the need for common electronic tools, referrals, and definitions. Work on the Health Links portfolio has driven local providers and the LHIN to think about communication and care in new ways and will continue to enable the discussion moving forward.

In 2015/16, the NSM LHIN provided supplemental funding for Health Links to ensure momentum continues in this community level approach. In conjunction with this funding, it was deemed necessary that additional local metrics be established for Health Links beyond what is collected provincially. This enhanced level of accountability is well aligned with the focus of the Advanced Health Links Model on performance management and oversight. Included in these metrics are indicators which identify the residential sub-geography of Health Links patients and referral sources. These indicators are intended to incent equity and collaboration and emphasize to Health Links the importance of working collaboratively with other providers who could be referring from primary care, acute care including inpatient and emergency, allied health, and community. The provision of additional funding also meant that the LHIN be explicit in the requirements of Health Links through performance agreements. This work is recognized provincially in the Advanced Health Links Model in its focus on increased accountability through greater oversight and an improved performance management framework. Revisions to the funding model will support LHIN accountability, allowing LHINs the discretion to fund local Health Links in alignment with both regional and provincial priorities.

eHealth

Ontario's Ministry of Health and Long-Term Care is taking steps to ensure that investments in eHealth advance the objectives of the *Patients First: Action Plan for Health Care* in a manner that is sustainable.²⁹ In order to leverage existing assets and build collaborative leadership with respect to eHealth, the MOHLTC has introduced the eHealth 2.0 initiative in support of the next phase of provincial health care transformation. The starting point for these changes is eHealth Governance 2.0. Informed by recent consultations, the MOHLTC has established the *eHealth Investment and Sustainment Board*, which will be the mechanism for engaging the health system in renewing the eHealth provincial strategy. The Board is mandated to provide advice to the MOHLTC on the eHealth Strategy 2.0 and once approved, to monitor its implementation. This strategy will guide all regions to maximize the benefits of existing assets, build on progress to date, and enhance capacity to evaluate return on investment. The work at the provincial level related to the eHealth Strategy will provide a framework and approach through which LHINs can achieve these deliverables within existing funding and while ensuring system sustainability.

Enabling technologies are transforming health care and driving system changes for all Ontarians. Information technology and information management are key elements in empowering patients and connecting the various sectors of the health care system. They provide a mechanism that allows patients, family, caregivers, and service providers to share information and coordinate services across the care continuum. Leveraging the eHealth 2.0 Strategy, the North Simcoe Muskoka LHIN will work with the MOHLTC and their eHealth delivery partners to ensure that investments in technology made at both the regional and provincial levels advance the goals of the *Patients First: Action Plan for Health Care*.²⁹ In support of the eHealth 2.0 Strategy, the LHIN will maximize the value and life of existing assets to reduce potential duplication and unnecessary early life cycling of systems and equipment.

Patient, Community and Stakeholder Engagement

Health service provider and patient input is a key driver of system change and helps to refine how provincial work is operationalized locally. In 2015, the NSM LHIN established a Patient Caregiver Family Advisory Panel to provide a forum for dialogue among community members as they advise the LHIN on issues related to health system goals and objectives. The panel provides system level advice and guidance to support the planning of LHIN and ministry strategic priorities. As the LHIN itself is not directly client facing, the panel provides LHIN staff and the Board of Directors with important input and perspectives from community residents, clients and caregivers with varied experiences in the local health care system. Diversity across the panel is encouraged with members from various

²⁹ Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Officer of the Minister, Ministry of Health and Long-Term Care; 2015.

age groups and geographic communities represented. A number of panelists have also self-identified as Francophone, First Nations, Lesbian, Gay, Bisexual, Transsexual, or Queer (LGBTQ).

In addition to the Patient Caregiver Family Advisory Panel, the NSM LHIN engages with local stakeholders through a variety of events, including the Annual Forum, sector-specific summits, and Regional Governance Sessions. These events allow us to engage with local stakeholders to keep them apprised of recent developments, to better understand their needs and concerns, and to ensure that decisions are informed by the input of local residents, health service providers and partner organizations from various communities. NSM LHIN leadership also meets regularly with leaders from local health service provider organizations via the Leadership Council, which provides overall direction for system transformation in the region. Together, these engagements guide and ground the work and help to ensure that the health care system is responsive to the needs of local communities.

Palliative Care Reform

The MOHLTC has recently announced the development of a new provincial body, the Ontario Palliative Care Network (OPCN), which will be jointly led by the LHINs and Cancer Care Ontario (CCO) to oversee the planning and implementation of fourteen regional palliative care networks and their respective local strategies. In Ontario, palliative care is currently delivered in large part by the home and community sector. The priority of the OPCN is to align all palliative care across the province to both the *Patients First: Action Plan for Health Care* and the *Declaration of Partnership*.^{30,31} The *Declaration of Partnership* is a guiding vision developed by the MOHLTC and stakeholders emphasizing the right to appropriate end-of-life care in the patient's setting of choice.³¹ Regional programs will be jointly accountable to the local LHIN CEO and the CCO Regional Vice President.

In addition to the new provincial body and anticipated new guidelines for the implementation of regional programs, palliative care within the region will be faced with pending changes to both the home and community sector and primary care. These changes could impact the local delivery of palliative care services. In planning for the regional palliative care strategy, the LHIN and its partners will diligently monitor anticipated changes to ensure they are appropriately managed, thereby minimizing disruption to patients and local providers. Further, in anticipation of guidelines and accountabilities for palliative care, the NSM planning committee will ensure alignment of the regional plan with MOHLTC expectations as known, monitoring for changes on an ongoing basis. The current fragmentation in palliative care across Ontario requires an organized provincial strategy delivered regionally to address local needs. Planning and system design at a sub-regional level will also be inclusive of palliative and end-of-life care services. As both provincial and regional direction with respect to palliative care takes shape, it will inform and direct the work by the LHIN with respect to end of life care, continuity of care, and regional planning.

Health System Funding Reform

In 2012, the Ministry of Health and Long-Term Care initiated Health System Funding Reform³² (HSFR) in order to foster quality and sustainability in the health care system. The objective of the reform is to move away from global budget funding to an activity-based model that reflects patient needs and clinical quality. The HSFR model has moved the funding allocation model from one that is predominately static to one that is more patient-centered, where funding is based on the services provided. Seventy percent of the overall funding provided to hospitals in 2015/16 was based on patient volumes, services provided, quality of care, and the needs of the local community. Due to the significant impact of HSFR on the type and level of hospital and community based services, it is a key driver of the work being completed at the local level.

HSFR is comprised of the Health-Based Allocation Model (HBAM) as the first component. HBAM estimates expected volumes and costs to identify an organization's share of overall funding for the sector. This funding allocation model is designed so that funding follows the patient. The model is designed to ensure that patient needs are met and the programs and services provided are well matched to demand. The HBAM formula also incorporates

³⁰ Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Office of the Minister, Ministry of Health and Long-Term Care; 2015.

³¹ Local Health Integration Networks and Quality Hospice Palliative Care Coalition of Ontario. *Advancing high quality, high value palliative care in Ontario: declaration of partnership and commitment to action*. Queen's Printer for Ontario; 2013.

³² Ministry of Health and Long-Term Care. *Health system funding reform (HSFR)*. Queen's Printer for Ontario; 2015.

demographics, geography, and social determinants within the scope of the definition of patient need and as such are reinforced as a critical element to local planning. As a second element, HSFR includes Quality Based Procedures (QBPs), which are targeted groups of patient services funded on a 'price x volume' basis that is associated with the quality of care provided. Handbooks or tool kits for each Quality Based Procedure are developed by experts at the provincial level to identify best practice related to a given clinical area.

It is the role of health service providers to determine the local model appropriate to meet the needs of the community and align with provincially identified best practices. The LHIN has a role to play in building overall capacity of the system by facilitating opportunities for providers to share innovations or lessons learned, and by redistributing existing resources as required. By fulfilling the LHIN roles related to planning, funding, engagement and oversight, the LHIN facilitates and enables the implementation of provincial directions related to HSFR, HBAM and QBPs.

LTC Home Renewal Strategy

In October 2014, the Ministry of Health and Long-Term Care (MOHLTC) announced the *Enhanced Long-Term Care Home Renewal Strategy*, which applies to approximately 30,000 eligible Long-Term Care (LTC) home beds in the province that have yet to be redeveloped under the original *Long-Term Care Renewal Strategy* (Phase 1).^{33,34} The strategy will require the redevelopment of approximately 900 long-term care beds in North Simcoe Muskoka as well as common areas within long-term care homes that no longer meet current design standards. The redevelopment plan will allow us to better meet the needs of residents with complex health needs, improve accessibility, and enhance safety for both residents and staff.

The NSM LHIN will provide oversight and support from a system perspective to the redevelopment process, as well as overseeing the capital planning process for LTC homes that have been accepted by the MOHLTC for renewal under the enhanced strategy. The MOHLTC acknowledges that the long-term care sector is a key contributor to delivering on *Patients First: Action Plan for Health Care*.³⁵ The direction of the *Enhanced Long-Term Care Home Renewal Strategy* and the redevelopment process will continue to guide the work of the NSM LHIN in its oversight and partnership with local operators of long-term care homes.³³ Together the work related to the renewal strategy will serve to support the provision of safe, high quality and person-centered care for residents of North Simcoe Muskoka.

³³ Ministry of Health and Long-Term Care. *Enhanced long-term care home renewal strategy*. MOHLTC; 2014.

³⁴ Ministry of Health and Long-Term Care. *Long-term care home development: long-term care home renewal strategy (phase1)*. MOHLTC; 2007.

³⁵ Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Officer of the Minister, Ministry of Health and Long-Term Care; 2015.



Integrated Health Services Plan Strategic Priority:

1.0 Improve Access to Appropriate Care

Description of the Priority

This Strategic Priority reflects the importance of ensuring that residents have timely access to the best possible care, in the most appropriate setting, in order to optimize health outcomes. Local data indicates that NSM residents are not always accessing care that is appropriate for their needs. While the primary care attachment rate in NSM is the third highest in the province, both the percentage of emergency department (ED) visits for less urgent / non-urgent conditions and the rate of ED visits that could have been better treated in a primary care setting exceed those of the province.³⁶ Emergency visit rates are an indicator of the degree to which other parts of the system may not be meeting patient needs and timely access to primary care is key in ensuring patients receive care in the most appropriate setting. Data also shows that patients frequently remain in hospital while awaiting placement in a more appropriate setting, which is reflected in the alternate level of care (ALC) rate. In North Simcoe Muskoka, the percentage of patients designated ALC who are occupying acute care beds is consistently among the highest rates in the province. In 2016/17, the NSM LHIN will focus on improving access in primary care, emergency care, mental health and addiction services, specialty care, and services for Francophone and First Nations, Métis, and Inuit (FNMI) communities.

Current Status

Primary Care

Primary care services within the North Simcoe Muskoka LHIN are offered through a variety of funding and practice models. Primary care consists of a continuum of services delivered by a wide range of providers who often work collaboratively, including: family medicine physicians, nurse practitioners, registered nurses, dietitians, social workers, health promoters, physiotherapists, kinesiologists, and traditional healers. Of the range of primary care models, only Community Health Centres (CHCs) are LHIN funded. In North Simcoe Muskoka these include the Barrie CHC, Chigamik CHC, and the South Georgian Bay CHC. In addition to the CHCs, primary care is also provided in the region by those either related to a solo practice, or one of six Family Health Teams, three Nurse Practitioner Lead Clinics, or two rural nursing stations. There are a number of different primary care practice models across the province that determine how client care is provided.

A primary care practice model is not the same as a Patient Enrolment Model (PEM). The seven different PEMs in the province dictate how the physicians within them are compensated. For example, a Family Health Team is a model of practice that can be aligned with different various PEMs. The physicians working within a Family Health Team in NSM are either affiliated with a Family Health Network or Family Health Organization as their payment model. Table 1 provides a breakdown of how many patients in NSM are aligned with each of the seven provincial patient enrolment models.

³⁶ Ministry of Health and Long-Term Care Health Analytics Branch. Environmental scan integrated health service plans 2016-19. Ministry of Health and Long-Term Care; 2015.

Table 1 – NSM Patients enrolled in Patient Enrolment Models (PEMs)

Primary Care Model	Enrolled Patients (%)
Comprehensive Care Model	0.6
Community Sponsored Agreement Model	0.0
Family Health Group	3.9
Family Health Network	10.7
Family Health Organization	84.9
Rural and Northern Physician Group Agreement	0.0
Other	0.0

Although the patient attachment rate in the NSM LHIN is the third highest in the province at 96.5%, timely access to the region's physicians remains a challenge. Only 29.4% of adults in NSM report being able to see their doctor or nurse practitioner either the same day or next day when ill and 61.1% of NSM patients reported having difficulty accessing after-hours care without visiting an emergency department.³⁷ In 2013/14, only 33.3% of patients in the North Simcoe Muskoka LHIN who were discharged from the hospital for an acute illness saw their physician within seven days following discharge.³⁸

A key success for 2015/16 in NSM is the hiring of a LHIN Physician Lead for Clinical Planning and System Integration. As a practicing family physician, the Physician Lead brings knowledge that is critical to the work related to primary care and the capability to optimize physician engagement opportunities. This engagement provides a valuable perspective on issues related to health system planning, performance and quality improvement. Work initiated in 2015/16 has led to the development of partnerships through the Primary Care Network and with the LHIN consulting physicians to improve efficiencies, performance and outcomes. The Physician Lead will continue to focus on influencing practice patterns, as well as creating a case for driving clinical change across the LHIN.

Mental Health and Addiction

The NSM LHIN has a robust mental health and addiction system that includes a wide spectrum of providers. The three Community Health Centres offer services within a primary care setting for those living with issues related to mental health and addiction. Individuals are also supported by community agencies, such as the Canadian Mental Health Association (Simcoe and Muskoka Parry Sound Branches), Kinark Child & Family Services, Wendat, New Path Youth & Family Services, as well as hospital outpatient programs. There are also three Schedule 1 designated facilities in the region that provide inpatient care to patients with severe or complex mental health and addiction needs: Waypoint Centre for Mental Health Care, Orillia Soldiers' Memorial Hospital, and Royal Victoria Regional Health Centre.

As of April 1, 2015, walk-in mental health counselling services are now available five days a week to clients throughout the NSM LHIN. Day and evening clinics are operated in Collingwood, Midland, Orillia, Barrie, and Bracebridge. In the first quarter of operation, over 250 clients were served and wait times for mental health and substance abuse management programs dropped by over 12%.^{39,40} Referral sources for the program include hospitals and family physicians (19%), community organizations (42%) and patient self-referrals/ referrals from family members (33%).³⁹

As part of *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*, the provincial government announced the allocation of 16 million to create 1,000 new supportive housing spaces in the province.⁴¹ In 2013, the NSM LHIN introduced a three year strategy to roll out the 48 new rental supplement units

³⁷ Ministry of Health and Long-Term Care Health Analytics Branch. Environmental scan integrated health service plans 2016-19. Ministry of Health and Long-Term Care; 2015.

³⁸ Ministry of Health and Long-Term Care Health Analytics Branch. Environmental scan integrated health service plans 2016-19. Ministry of Health and Long-Term Care; 2015.

³⁹ Catholic Family Services of Simcoe County. Quarterly reporting April-June 2015. CFSSC; 2015.

⁴⁰ ConnexOntario Health Services Information. North Simcoe Muskoka LHIN Community mental health and addictions wait times summary July 2015. ConnexOntario; 2015.

⁴¹ Ministry of Health and Long-Term Care. Open minds, healthy minds. Ontario's comprehensive mental health and addictions strategy. Ministry of Health and Long-Term Care; 2011.

that are to be allocated within NSM. In years one and two of the program, 37 housing spaces were allocated with the remaining units to be allocated in 2016/17. In addition to providing affordable housing, this initiative ensures that individuals have access to case management and self-management support to aid in the transition to their new home and community.

The County of Simcoe also received rental supplement funding through the Ministry of Municipal Affairs and Housing. As a LHIN partner, the County opted to dedicate their rental supplement resources to individuals with mental health and addiction needs; the LHIN supported the flow of funding and the allocation of these units through LHIN funded organizations. Access to affordable housing for those with mental health and addiction was improved by both initiatives and the partnership with the County of Simcoe will be one that the LHIN aims to emulate with other municipal partners in the future.

Emergency Departments

In North Simcoe Muskoka, there are six emergency departments across five hospital corporations. Visits to emergency departments are triaged by acuity according to the Canadian Triage and Acuity Scale (CTAS). In 2013/14, there were 253,491 visits to NSM emergency departments, of which the largest proportions were triaged as CTAS III (urgent) and CTAS IV (less urgent).⁴² Table 2 provides a breakdown of emergency visits by CTAS for 2013/14.

Table 2 – Emergency department visits by CTAS, 2013/14

	Royal Victoria Regional Health Centre	Collingwood General and Marine Hospital	Georgian Bay General Hospital	Muskoka Algonquin Healthcare Huntsville	Muskoka Algonquin Healthcare Bracebridge	Orillia Soldiers' Memorial Hospital
CTAS I	438	155	281	48	69	310
CTAS II	19,075	4,210	6,410	2,256	1,769	6,157
CTAS III	35,176	14,332	17,437	9,433	9,055	16,824
CTAS IV	24,245	11,288	18,091	10,381	9,384	28,288
CTAS V	2,060	1,686	2,102	571	618	1,342
Total	80,994	31,671	44,321	22,689	20,895	52,921

Ensuring that local EDs have adequate capacity to respond to emergencies is critical, because when hospitals are struggling to find beds, admitted patients are often left waiting in the ED until an inpatient bed becomes available. As a result, departments struggle to ensure physicians assess patients in a timely manner, ambulances are offloaded within an appropriate timeframe, and staff have enough time to ensure that patients understand discharge instructions and feel prepared to manage their conditions when they go home.

Challenges in accessing primary care in a timely manner also mean that NSM emergency departments are left managing conditions that would best be treated elsewhere. In 2013/14, the rate of ED visits for conditions best treated in an alternative primary care setting for NSM residents was 30.2 per 1,000 population, which was significantly higher than the Ontario rate (18.5 per 1,000 population).⁴³ Further, the proportion of visits to NSM EDs (43.4%) that were classified as CTAS IV and V (less urgent / non-urgent), was also higher than the corresponding proportion for Ontario (36.7%).⁴³ However, data shows that both ED visits for conditions best treated in primary care and the proportion of lower acuity visits have decreased over time.

Acute Care Utilization

Acute care in North Simcoe Muskoka is provided by five hospital corporations. Across these five hospital corporations, there were a total of 788 average beds staffed and in operation in fiscal 2014/15. The combined occupancy rate for NSM LHIN hospitals was 90% for the same time period.

⁴² Internal analysis based on 2013/14 data from the National Ambulatory Care Reporting System (NACRS). Accessed via IntelliHealth; June 2014.

⁴³ Ministry of Health and Long-Term Care Health Analytics Branch. Environmental scan integrated health service plans 2016-19. Ministry of Health and Long-Term Care; 2015.

Acute care utilization data provides information on patient days, as well as both acute and ALC separations (discharges, deaths, sign-outs and transfers). In fiscal 2013/14, there were a total of 204,841 patient days in NSM LHIN hospitals, comprised of 160,990 acute days and 43,851 ALC days. For 2013/14, there were 33,180 acute separations, with an average acute length-of-stay of 4.9 days. In the same period, there were 2,309 ALC separations, with an average ALC length-of-stay of 19.0 days. Acute separations and total days increased for NSM hospitals between 2010/11 and 2013/14, while acute days decreased. During the same period, ALC separations decreased while ALC days increased. Residents of North Simcoe Muskoka had a higher acute care separation rate (82.7 per 1,000 population) than the provincial average for 2013/14 (73.2 per 1,000 population). Of note, 22.4% of acute separations for NSM LHIN residents were from hospitals outside the region.⁴⁴

NSM LHIN hospitals have significant numbers of visits from individuals with complex and chronic health needs and issues related to mental health and addiction. This population is reflected in both emergency department visits and inpatient admissions, and is an indication of the extent to which chronic disease prevalence and morbidity affects local health care utilization. Table 3 provides a breakdown of ED visits and inpatient encounters for complex and chronic and mental health and addiction patients by facility for 2013/14.⁴⁵

Table 3 - ED visits and inpatient encounters for complex and chronic and mental health / addiction patients by facility

	Percentage of Emergency Visits		Percentage of Inpatient Encounters	
	Chronic and Complex Patients	Mental Health Patients	Chronic and Complex Patients	Mental Health / Addiction Patients
Royal Victoria Regional Health Centre	10.8%	11.2%	25.9%	15.3%
Collingwood General And Marine Hospital	9.8%	7.4%	30.7%	16.7%
Georgian Bay General Hospital	11.7%	9.8%	44.0%	23.1%
Orillia Soldiers' Memorial Hospital	13.7%	12.7%	40.2%	24.4%
Muskoka Algonquin Healthcare - Huntsville	9.5%	8.7%	41.8%	23.5%
Muskoka Algonquin Healthcare - Bracebridge	12.7%	11.3%	46.8%	25.6%
Waypoint Centre For Mental Health Care - Provincial	--	--	20.6%	96.8%
Waypoint Centre For Mental Health Care Centre - Regional	--	--	41.2%	95.6%
Non-North Simcoe Muskoka Hospital	9.6%	9.3%	34.1%	12.6%

Stroke

Each year approximately 900 patients in the NSM LHIN present to the emergency department with a stroke or transient ischemic heart attack (TIA); of these approximately 700 are admitted to an acute hospital for care.⁴⁶

All local hospitals currently provide some level of stroke care; however, the Enhanced District Stroke Centre is located at Royal Victoria Regional Health Centre (RVH). RVH provides cross-continuum stroke services from hyperacute, through to acute and rehabilitative care, as well as providing stroke prevention services. When patients are admitted to hospital, acute stroke services are provided mainly on general medical units, with varying levels of service across the LHIN. Only two hospitals in North Simcoe Muskoka (RVH and Muskoka Algonquin Healthcare – Huntsville) provide access to thrombolytic drugs, specifically tissue plasminogen activator (tPA) for ischemic stroke.

⁴⁴ Ministry of Health and Long-Term Care Health Analytics Branch. Environmental scan integrated health service plans 2016-19. Ministry of Health and Long-Term Care; 2015.

⁴⁵ Internal analysis based on 2013/14 data from the Discharge Abstracts Database (DAD), the National Ambulatory Care Reporting System (NACRS) and Ontario Mental Health Reporting System (OMHRS). Accessed via IntelliHealth; January 2015.

⁴⁶ North Simcoe Muskoka LHIN-Wide Integrated Stroke Program. Expression of interest for integrated funding models. North Simcoe Muskoka LHIN, 2015.

Under the current model, patients are repatriated to their home hospital post-tPA for the remainder of their inpatient stroke care. As of the most recent Ontario Stroke Report Card, only 5.9% of NSM patients had access to a specialized stroke unit in 2013/14, as compared to a provincial benchmark of 62.7%.⁴⁷

Access to stroke rehabilitation also varies across the region. Designated inpatient rehabilitation is provided at Royal Victoria Regional Health Centre (RVH), Orillia Soldiers' Memorial Hospital (OSMH) and Georgian Bay General Hospital (GBGH). RVH and OSMH are the main providers of outpatient stroke rehabilitation in the region, although the CCAC provides some stroke care in the community through its stroke pathway. Slow stream rehabilitation is also available within some Complex and Continuing Care settings in the LHIN.

Cardiac

Cardiac services in North Simcoe Muskoka are provided by local acute care facilities and through a partnership with Southlake Regional Health Centre (SRHC) for interventional cardiology procedures. While many cardiac services including diagnostic testing, rehabilitation / risk factor management, and outpatient clinics are available locally, NSM is currently the only LHIN in the province without advanced cardiac care services. This means that more than 3,600 patients annually must travel to centres outside the region for cardiac care.⁴⁸ Currently, approximately 80% of diagnostic catheterization and percutaneous coronary intervention (PCI) for NSM residents is provided by Southlake Regional Health Centre.⁴⁹ The additional travel poses a risk in that some NSM residents are unable to access PCI within standard targets for myocardial infarctions.

In July 2015, the province announced the approval of RVH's Advanced Cardiac Care Centre, which will be developed in partnership with Southlake Regional Health Centre and the Cardiac Care Network. Recent data shows that in 2012/13, 2,660 diagnostic catheterizations and 820 PCIs were performed on residents of NSM LHIN demonstrating that the region has the critical mass required to establish a PCI program.⁴⁹

Critical Care

Critical care services treat patients with life threatening conditions, with the objective of maintaining organ system functioning to allow the patient's underlying injury or illness to be treated. Critical care services are provided in all five NSM acute care hospitals, with a total of 43 adult ICU beds across the region. The NSM LHIN currently has three community hospitals (CGMH, MAHC, GBGH) with limited access to intensivists, respirologists and critical care educated nursing staff. Given these kinds of system constraints, collaboration, partnership, technology and extramural critical care support via outreach are all key enablers to best serve patients and ensure continued health system function.

Diverse Populations

According to Census data, 2.8% of NSM LHIN residents identify French as their mother tongue.⁵⁰ Among the NSM LHIN's five communities, the Midland-Penetanguishene area has the highest proportion of residents who reported French as their mother tongue.⁵¹ There are 26 areas in the province that are 'designated' under the *French Language Services Act*, meaning that Francophones comprise at least 10% of the population.⁵² In North Simcoe Muskoka, the Town of Penetanguishene and both Essa and Tiny Townships are considered to be designated areas under the Act.⁵³

⁴⁷ Ontario Stroke Network. Ontario stroke evaluation report card 2015. Institute for Clinical Evaluative Sciences; 2015.

⁴⁸ Royal Victoria Regional Health Centre. Improving access to cardiac care in North Simcoe Muskoka. RVH; 2015.

⁴⁹ Royal Victoria Regional Health Centre. Stage 1: Proposal for cardiac catheterization / PCI project. RVH; 2014.

⁵⁰ Ministry of Health and Long-Term Care Health Analytics Branch. Environmental scan integrated health service plans 2016-19. Ministry of Health and Long-Term Care; 2015.

⁵¹ Ministry of Health and Long-Term Care Health Analytics Branch. Health Link demographic, census, and utilization profile. Ministry of Health and Long-Term Care; 2013.

⁵² Ontario, French Language Services Act, R.S.O. 1990, c. F.32

⁵³ Ontario Office of Francophone Affairs. Map of designated areas. Queen's Printer for Ontario; 2013.

LHINs, as Crown agencies and local health system planners, are responsible for ensuring that Ontario's Francophone population has equitable access to a full range of health services in French. Correctly identifying which health service providers should provide services in French will help improve access to and accessibility of French language health services for this population. There are currently eight health service providers in the region that are identified and one that is designated to provide health care services in French.

According to the 2011 Census, 4.3% of NSM residents self-identify as Aboriginal, which is the third highest proportion among the fourteen LHINs.⁵⁴ There are four First Nations communities in North Simcoe Muskoka, including Beausoleil First Nation, Chippewas of Rama First Nation, Wahta Mohawks First Nation, and Moose Deer Point First Nation. There are also many individuals living outside of these communities who self-identify as First Nations, Métis, or Inuit. The Midland-Penetanguishene area is home to the largest proportion of NSM residents who self-identify as Aboriginal.⁵⁵ The LHIN funds a variety of services through six organizations whose main focus is the provision of services for individuals who identify as First Nations, Métis, or Inuit.

⁵⁴ Ministry of Health and Long-Term Care Health Analytics Branch. Environmental scan integrated health service plans 2016-19. Ministry of Health and Long-Term Care; 2015.

⁵⁵ Ministry of Health and Long-Term Care Health Analytics Branch. Health Link demographic, census, and utilization profile. Ministry of Health and Long-Term Care; 2013.

Goal 1.1: Enhance access to timely and appropriate primary care.

Consistency with Government Priorities

High quality, accessible, and efficient primary care directly aligns with the provincial direction for health care as outlined in the *Patients First: Action Plan for Health Care*.⁵⁶ As noted by Minister Hoskins in his February 2nd address to the Empire Club of Canada, “We need a front door to our medical system that is open 24/7 and that front door should be a dynamic primary care system with team-based integrated and coordinated care, leveraging the skills of more health care providers and with fewer unattached patients.”⁵⁷

Appropriate and timely access to primary care reduces the burden on other aspects of the system, such as acute care and emergency services, thereby making the system more efficient and sustainable. Improved referrals and connectivity between providers will ensure that patients are directed to the appropriate services in a timely and effective way. Primary care within the North Simcoe Muskoka LHIN is usually the initial access point for patients entering Ontario's health care system. Typically, this provider acts as the principle point of consultation for patients and coordinates other types of care that the patient may need.⁵⁸

Primary care reform will be a defining period in the development of Ontario's health care system. Creating functional integrated networks of care will improve multidisciplinary patient care in the community. The NSM LHIN is reinforcing and enabling a comprehensive primary care system in order to improve access to appropriate care. The work in primary care is not only limited to improved access, but also will significantly contribute to the achievement of the LHIN strategic priorities related to building capacity, enhancing coordination and driving sustainability.

Action Plans and Interventions

Action Plans and Interventions		2016/17		2017/18		2018/19	
		Status	%	Status	%	Status	%
1.1.1	Leverage existing Health Quality Ontario practice reports and office management resources for advanced access scheduling in primary care to ensure same day / next day access and access for CTAS IV and V complaints.	Not yet Started	10	In Progress	40	In Progress	50
1.1.2	Increase access to primary care by increasing community awareness of after-hours clinics, increasing clinic hours and accessibility for unattached patients and integrating full scope nurses and nurse practitioners into after-hours clinics to increase health human resources.	Not yet Started	25	In Progress	25	In Progress	25
1.1.3	Leverage existing customer service resources available through the Ontario Medical Association and Association of Family Health Teams of Ontario to train primary care office staff on ways to improve patient satisfaction.	Not yet Started	10	In Progress	40	In Progress	50
1.1.4	Connect unattached Health Links patients with a primary care provider at discharge.	In Progress	50	In Progress	25	In Progress	25

⁵⁶ Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Office of the Minister, Ministry of Health and Long-Term Care; 2015.

⁵⁷ Minister Dr. Eric Hoskins. *Patients first action plan for health care* (speech), February 2, 2015.

⁵⁸ Ministry of Health and Long-Term Care. 2012 agreement for Ontario doctors: primary care. MOHLTC; 2012.

Measuring Success

- Increase percentage of family practice offices with some form of advanced access scheduling
- Increase percentage of patients reporting that they have access to same or next day appointments as needed
- Decrease the percentage of individuals who report that they have difficulty accessing primary care in the evenings or on the weekends
- Increase number of primary care office staff trained in customer service
- Increase percentage of Health Links patients connected to a (local) primary care provider upon discharge
- Decrease number of CTAS IV, V Emergency Department visits
- Increase percentage of individuals attached to a Primary Care provider
- Increase percentage of primary care patients satisfied with overall experience with reception staff
- Decrease rate of emergency visits for conditions best managed elsewhere (MLAA Indicator)
- Decrease readmissions within 30 days for selected HBAM Inpatient Grouper (HIG) conditions (MLAA Indicator)

Risks and Mitigation Strategies

Risks	Mitigation Strategy
▪ Level of physician support could create a risk to initiatives intended to improve access to primary care.	Reduce likelihood through change management, engagement and strengthening relationships with broad stakeholders including primary care, the Ontario Medical Association, Ontario College of Family Physicians, and the Association of Family Health Teams of Ontario.
▪ Access to human resources to support and manage the accountability mechanisms for primary care are uneven and may negatively impact some providers.	Avoid risk by collaborating across local community Health Links, to maximize the use of existing resources and develop contingency plans to move forward without additional funding.
▪ If timely and valid data relating to access and patient outcomes is difficult to collect, analyze and share across providers, then it also becomes difficult to plan based on evidence and to provide the appropriate level of monitoring and oversight.	Reduce the likelihood by collaborating with the Ministry of Health and Long-Term Care, the five regional Health Links and local partners to simplify data collection, improve sharing across providers, and strengthen data quality.

Key Enablers

Established defined communities within the region – Five well-established and clearly distinguishable sub-geographies have been in place for some time in NSM. These include: Barrie and area, Orillia and area, the District of Muskoka, Midland/Penetanguishene and area, and Collingwood/Wasaga Beach and area. Each of these communities have an approved and functioning Health Link, aligned to the same geographic boundaries. Moving forward, these communities will benefit immediately from existing partnerships and accountabilities that currently link primary care with other health care providers.

Homogeneity across provider models – Approximately 96% of NSM patients are part of a primary care Patient Enrollment Model, and 87.5% of patients are enrolled to a physician model that is part of a Family Health Team (FHT). In addition, over half of all primary care physicians in the LHIN are working as part of a FHT. Each of the LHIN's five communities has an established FHT located within its geographic boundaries. In light of this, future work within primary care will be a natural evolution of the existing primary care system. Although the NSM communities are all at various stages of participation within the FHT model, Primary Care Renewal will provide an opportunity to optimize the interdisciplinary model of the region's existing FHTs to further develop and promote a seamless approach to patient care.

Health Links - The experiences with Health Links over the past two years will enable the work to be completed with primary care. Health Links as a collaborative service delivery model that continues to challenge local health system providers and partners to understand where improvements are required, how the cost of care is calculated across the continuum, and where savings, value, and efficiencies need to be established to ensure sustainability. Primary care

initiatives will leverage the lessons learned from Health Links and the model of successful community level collaboration.

LHIN Physician Lead for Clinical Planning and System Integration and NSM Primary Care Network – The NSM LHIN Physician Lead for Clinical Planning and System Integration will support LHIN work in enabling access to timely and appropriate primary care. The Lead will facilitate relationships, act as a champion and subject matter expert, and play a key role in the leadership of the NSM LHIN Primary Care Network. The Primary Care Network is a group of local physician champions who work collaboratively to move the system forward, identify potential issues, and educate and engage their peers to bring their perspective and contribute to new initiatives.

Regional Quality Table – Over the past year, the NSM LHIN has partnered with Health Quality Ontario to work towards establishing a Regional Quality Table. This group will provide a forum to discuss quality improvement strategies across the LHIN and align these strategies with regional and provincial strategic directions. It will be led by a regional clinical chair and will be comprised of regional clinical leads, sector leaders, and a Health Quality Ontario regional Quality Improvement Specialist. This table will be a valuable resource for the NSM LHIN, as it will provide a venue to discuss performance improvement, align efforts across sectors, develop standardized methods of care, and share best practices throughout the region.

Goal 1.2: Enable timely access to and appropriate use of emergency services.

Consistency with Government Priorities

Ensuring access to and appropriate use of local emergency departments (EDs) is well aligned to the *Patients First: Action Plan for Health Care* in terms of access to quality care.⁵⁹ It is also aligned with the provincial *Emergency Room Wait Times Strategy*, which recognizes that timely access to emergency services requires improvement across the system.⁶⁰ The provincial strategy is based upon enhancing alternatives to emergency services, improving capacity and operating processes in emergency departments, supporting discharges for patients requiring alternate level of care (ALC) through increased home and community supports, and reporting of ED wait time measures.

Work across the system supports local emergency departments by ensuring that individuals receive care in the most appropriate setting. In many cases, use of emergency services demonstrates failures, waits or pressures in other parts of the system. Reducing the number of people who utilize emergency services for conditions better served elsewhere is the measure of success for other NSM LHIN goals including access to primary care, home and community care, mental health, chronic disease management, and services for seniors. Other improvements specific to the ED include regional implementation of electronic triage to support consistent application of the Canadian Triage and Acuity Scale (CTAS). This impacts quality and safety of emergency care, as well as reducing time spent in the ED. Local efforts also include the development of a regional health human resources (HHR) plan for ED care to optimize local HHR capacity, in alignment with the provincial strategy. These system level and ED-specific strategies serve to support the goals of the provincial *ER Wait Times Strategy*, as well as supporting the broad goals of the *Patients First: Action Plan for Health Care*.^{59,60}

Action Plans and Interventions

Action Plans and Interventions	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
1.2.1 Develop a regional plan for health human resources for emergency department (ED) care in collaboration with Health Force Ontario and local ED and physician leadership.	Not yet Started	25	In Progress	25	In Progress	50
1.2.2 Implement case management into the Emergency Department to ensure that community resources are optimized and discharge care implemented.	Not yet Started	25	In Progress	25	In Progress	50
1.2.3 Develop an integrated LHIN-wide Influenza Surge Plan to maintain flow through the Emergency Department and ensure continued access to appropriate care.	In Progress	50	In Progress	50		

Measuring Success

- Increase percentage of EDs reporting optimal staffing levels on HFO surveys
- Increase number of EDs with case management services
- Decrease 90th percentile ED length of stay for non-admitted low acuity patients
- Decrease 90th percentile ED length of stay for non-admitted high acuity patients
- Decrease 90th percentile ED length of stay for minor / uncomplicated patients (MLAA Indicator)
- Decrease 90th percentile ED length of stay for complex patients (MLAA Indicator)

⁵⁹ Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Office of the Minister, Ministry of Health and Long-Term Care; 2015.

⁶⁰ Ministry of Health and Long-Term Care. *Ontario's emergency room wait times strategy*. Queen's Printer for Ontario; 2015.

Risks and Mitigation Strategies

Risks	Mitigation Strategy
Various accountabilities in partners for emergency preparedness (LHIN, municipalities) can make it difficult to implement and manage change.	Reduce likelihood by building collaborative relationships and shared vision with ED stakeholders.
Overall, ED success is reliant upon the success of the system. The inherent risk for ED is that attention gets diverted from ED specific tasks and projects when the system stresses reach a critical point.	ED leadership continues to lend energy to efforts across the system which will ultimately ensure their own success such as those related to primary care or ALC reduction.

Key Enablers

Primary Care – Changes within primary care could, if implemented, increase accountability within the sector for access. Ensuring that patients are seen in the most appropriate place with increased access to primary care enables the efficiency and appropriateness of care that is delivered in emergency departments. Emergency department efficiency supports both the quality of care for those who are attending, and a reduced length of stay for non-admitted patients. Also, by integrating case management from CCAC into primary care, care planning for patients can be coordinated between ED and primary care, ultimately improving discharge from ED and hopefully reducing avoidable ED presentations.

Enabling Technology – Technology enables access to appropriate care in emergency departments in a number of ways. It facilitates improved information sharing about patient presentation and involvement of partners in caring for patients. The electronic Care Coordination Tool (CCT) will ensure that emergency department staff are aware of care plans that are in place for complex vulnerable patients. It will also provide access to information that could improve the care patients receive or avoid a hospital admission when appropriate. Repeat emergency department visits would more easily be flagged and could be brought to the attention of primary care when the physician receives notice of an emergency department visit through eNotification.

Emergency Department Steering Committee – In North Simcoe Muskoka, there is an Emergency Department Steering Committee which is a collaborative gathering of administrative and clinical leaders in emergency medicine. The committee enables the spread of successful initiatives to improve emergency department flow and quality. For example, standard medical directives were established by the committee and implemented across the LHIN. The position of LHIN physician leadership for primary care and the emergency department is shared. This allows for improved integration between access to care in the community and ED utilization. As primary, home and community care all continue to evolve, emergency departments across the LHIN will be involved in proactive planning thereby shaping change rather than responding to the impacts of the collective system.

Cross Sector Collaborations – The NSM LHIN has engaged cross sector partners such as Public Health in prevention discussions such as flu surge planning. Collaboration between acute care, emergency medical services (EMS) and municipalities enable emergency departments to better plan for capacity when the need for emergency services may be highest. This collaboration and preparation can reduce the surge or influx of individuals that can occur in correlation with emergencies, public events, and times when access to care can be more limited, such as holidays or flu outbreaks.

Goal 1.3: Improve access to high quality mental health and addiction services.

Consistency with Government Priorities

Improving access to high quality mental health and addiction services is a local area of focus due to the opportunity within the LHIN to improve outcomes for individuals with complex and chronic health needs including mental health and addiction. In the *Patients First: Action Plan for Health Care*, the Ministry of Health and Long-Term Care highlighted the provision of the right care for those living with mental health and addiction as critical to the performance and sustainability of Ontario's health care system.⁶¹ *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* also identifies the provision of the right service at the right time in the right place as critical to the effective and efficient delivery of high quality mental health and addiction services in Ontario.⁶² These elements have also been identified by the Provincial Leadership Advisory Council for Mental Health and Addictions.

By focusing on access, the NSM LHIN has aligned itself with these provincial directions. Over the next year, the NSM LHIN will work with sector partners, health service providers, and community agencies to drive change that includes prevention and promotion, early intervention services, new supportive housing initiatives, counselling and crisis supports, and new approaches to system integration and alignment.

Action Plans and Interventions

Action Plans and Interventions	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
1.3.1 Update a current state inventory for mental health and addiction services across the LHIN. Include LHIN funded and non-funded services and utilization rates.	In Progress	80	In Progress	20		
1.3.2 Review and revise as needed, indicators related to access to mental health and addiction services and support.	Not yet Started	100				
1.3.3 Support the management, implementation, and evaluation of the three year 1,000 unit rental supplement initiative.	In Progress	100				
1.3.4 Support the expanded adoption of the CitiCall provincial adult and child/youth MHA inpatient bed registry and the accuracy of the data through LHIN facilitation and coordination with service providers.	In progress	50	In Progress	50		
1.3.5 Increase access to mental health supports through walk-in clinics.	In Process	70	In Progress	30		

Measuring Success

- Increase number of rental units allocated and implemented
- Increase number of NSM hospitals with Schedule 1 beds actively participating in adult and child/youth bed boards
- Increase number of visits to mental health and addiction walk in clinics
- Decrease hospital admission and readmission rates for mental health, by age group
- Decrease hospital admission and readmission rates for substance abuse, by age group
- Decrease ALC to mental health and addiction services
- Decrease repeat unscheduled ED visits within 30 days for mental health conditions (MLAA Indicator)
- Decrease repeat unscheduled ED visits within 30 days for substance abuse conditions (MLAA Indicator)
- Decrease ALC rate (MLAA Indicator)

⁶¹ Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Office of the Minister, Ministry of Health and Long-Term Care; 2015.

⁶² Ministry of Health and Long-Term Care. *Open minds, healthy minds. Ontario's comprehensive mental health and addictions strategy*. Ministry of Health and Long-Term Care; 2011.

Risks and Mitigation Strategies

Risks	Mitigation Strategy
Service or indicator data may be limited, untimely, or not valid. This could impact the quality of a current state inventory or indicator selection/development.	Reduce likelihood by leveraging the expertise of the LHIN performance team to identify valid data sources.
The NSM LHIN currently has an adult bed registry. To implement the CritiCall system will require health service providers to use both systems. This overlap creates a risk to the CritiCall project in terms of provider engagement and support.	Reduce likelihood through engagement of health service providers. Seek opportunities for system improvements which would facilitate the integration between the NSM LHIN registry and the CritiCall registry.

Key Enablers

Provincial Mental Health and Addictions Leadership Advisory Council – This group, established by the Ministry of Health and Long-Term Care, represents diverse sectors that work on mental health and addiction issues across the province. The council will work to meet five specific priorities and has a sub-committee made up of Mental Health and Addiction LHIN Leads, three LHIN CEOs, and a number of Senior Directors. This committee will enable local work as a central communication linkage between the MOHLTC, the LHINs, and the mental health and addiction sector. The NSM LHIN Mental Health and Addiction Lead currently sits on this council.

Mental Health and Addiction Project Team – This group is made up of key leaders within the NSM LHIN who provide mental health and addiction services to clients. The LHIN, in coordination with the Project Team, work to enhance access to mental health and addiction services for patients through the development, planning, implementation and evaluation of new and existing programs, services and initiatives. The Project Team provides a consistent forum for discussion and collaboration where the LHIN can engage with health service providers and leverage their collective clinical expertise and leadership.

NSM LHIN Patient Family Caregiver Advisory Panel – The Patient Family Caregiver Advisory Panel will play a crucial role in the development of each goal outlined in this plan. In relation to the goal of access, the panel will work with the LHIN Lead as well as the Mental Health and Addiction Project Team to review and provide guidance on new and existing directives, initiatives, programs and services. In doing so, the Panel will play an important role in ensuring that the voice and perspective of patients, caregivers, and families are included in planning, implementation and evaluation processes.

Goal 1.4: Increase access to specialty care closer to home.

Consistency with Government Priorities

A key priority of the *Patients First: Action Plan for Health Care* is faster access to the right care closer to home.⁶³ Electronic consultation is identified provincially as one enabler to improving access to services closer to home for patients. In alignment with the province's mandate to protect the sustainability of the system for future generations, these enhancements to care via increased utilization of telemedicine resources will be made by leveraging existing assets with little to no further investment.

Provincial leadership and planning for Ontario's stroke system is provided by the Ontario Stroke Network (OSN). In alignment with national and OSN best practice recommendations, the LHIN will move towards regionalizing stroke care through the implementation of an integrated model. The Cardiac Care Network is an advisory body to the Ministry of Health and Long-Term Care and is responsible for assisting with the planning, coordination, implementation, and evaluation of cardiovascular care across the province. In its 2013 guidance document, *Development of a Regional Cardiac Program*, the Cardiac Care Network identified core competencies and functions of a regional cardiac program.⁶⁴ NSM's cardiac program will align with these requirements at a local level. Finally, the MOHLTC's *Critical Care Strategy* was developed based on the recommendations of the Ontario Critical Care Steering Committee. Critical Care Services Ontario (CCSO), the body responsible for the implementation of the provincial strategy, has recently developed the *Ontario Critical Care Plan 2015-18*.⁶⁵ This plan identifies five strategic goals that inform the activities of the local Critical Care Network.

Action Plans and Interventions

Action Plans and Interventions	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
1.4.1 Develop a regional telemedicine work plan with the Ontario Telemedicine Network and service providers. Identify gaps that could be filled for specific target populations via virtual care. Monitor implementation and adoption.	In Progress	100				
1.4.2 Identify and connect French speaking clinicians with patients in the NSM region via telemedicine.	In Progress	100				
1.4.3 Provide project management resources to evaluate the health needs and current levels of health system utilization in the Penetanguishene community. Work with health service providers to move the proposal forward as it is deemed appropriate.	In Progress	100				
1.4.4 Implement an integrated funding bundle for stroke care using the Transitional Stroke Care and Rehabilitation Model to provide more comprehensive, coordinated, and timely access to patient care.	Not yet Started	100				
1.4.5 Implement plan for a Regional Cardiac Program that conforms with the core competencies and functions defined by the Cardiac Care Network.	In Progress	50	In Progress	25	In Progress	25
1.4.6 Develop and implement a regional Critical Care Outreach Team (CCOT) to leverage critical care expertise outside of Intensive Care Units (ICUs) and in lower intensity ICUs.	In Progress	25	In Progress	25	In Progress	50

⁶³ Office of the Minister, Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Ministry of Health and Long-Term Care; 2015.

⁶⁴ Cardiac Care Network of Ontario. *Development of a regional cardiac program: Core competencies and functions of a regional cardiac program*. CCN; 2013.

⁶⁵ Critical Care Services Ontario. *Ontario critical care plan 2015-18*. CCSO; 2015.

Action Plans and Interventions	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
1.4.7 Develop a plan to support implementation of the Rehabilitative Care Alliance Mandate II Definitions Framework for bedded and community levels of rehabilitative care.	In Progress	100				
1.4.8 Develop and implement inpatient and outpatient rehabilitation services for stroke and cardiac care.	In Progress	50	In Progress	50		

Measuring Success

- Increase number of clinical events delivered through telemedicine
- Increase number of clinical events delivered through telemedicine in French
- Decrease wait times for inpatient and outpatient rehabilitation for stroke
- Increase number of patient consults by Critical Care Outreach Teams
- Increase proportion of stroke (excluding TIA) patients discharged from acute care who received a referral for outpatient rehabilitation
- Increase median FIM efficiency for moderate stroke in inpatient rehabilitation
- Increase proportion of stroke/TIA patients discharged from acute care to Long-Term Care/Complex Continuing Care (excluding patients originating from LTC/CCC)

Risks and Mitigation Strategies

Risks	Mitigation Strategy
▪ Potential movement of system resources creates a risk to hospital's current program operation. This results in a risk in terms of a lack of buy in for the regional approach for stroke care.	Risk is avoided by implementation of LHIN authority to facilitate an integration across all providers by reallocation of funded stroke rehab volumes. A communication strategy will also be developed to help the public understand rationale for potential movement of resources. Extensive efforts have been made over recent years to engage the hospital partners in stroke integration and the majority of partners are focused on collaboration on this project as a result of this engagement.
▪ Currently, NSM is the only region in the province that does not have advanced cardiac services. This factor presents a current risk for patient health outcomes. However, filling this gaps means that volumes will need to be reallocated from other facilities from outside the region. This presents a challenge in terms of engagement and support for the integration of services.	Risk is mitigated with continued engagement and negotiation with neighbouring LHINs. The principles of facilitated integration will be followed in the continued partnerships between the LHINs and providers of cardiac care for NSM LHIN residents.

Key Enablers

Existing Telemedicine Resources – The Ontario Telemedicine Network (OTN) and the existing telemedicine assets held by providers of the NSM LHIN will be used to facilitate the provision of care across a range of portfolios to bring care and speciality services closer to or into the patient's home. Telemedicine services have been incorporated into the models being developed for stroke, cardiac, and critical care both in terms of better access to specialists and increasing capacity via educational opportunities delivered through telemedicine. Critical Care Outreach teams will use telemedicine to connect to specialists such as internists and respirologists to enable equitable patient care across the region 24 hours a day, seven days a week.

Stroke Steering Committee – The Stroke Steering Committee is comprised of hospitals which represent the acute care centres that provide stroke care in the southern, central and northern portions of the NSM region. The committee also includes partners from other regional hospitals, emergency medical services (EMS), specialists, the NSM Community Care Access Centre and other community organizations. The work of the committee is closely tied to the work completed by the Health System Funding Reform Local Partnership which provides regular updates to the Stroke Steering Committee. The committee enables collaboration in the establishment of standards, benchmarks and guidelines as foundational for the realization of an integrated stroke program.

Critical Care Steering Committee – The Critical Care Steering Committee includes representatives of the hospitals within NSM. Their role is to collaborate and support the implementation of the *Ontario Critical Care Plan 2015-18*.⁶⁶ The key goal is to provide standard and consistent care across the region despite the differing capacities to deliver critical care services at each facility. The group aligns most with acute care; however, it will also allow emergency departments across the LHIN to access the specialized intensivist resources available at the region's larger acute care facilities, thereby also enabling goals related to appropriate use of the region's emergency departments.

⁶⁶ Critical Care Services Ontario. Ontario critical care plan 2015-18. CCSO; 2015.

Goal 1.5: Improve local access to and accessibility of French language health services.

Consistency with Government Priorities

Approximately half a million Francophones reside in Ontario. This represents Canada's largest French-speaking community outside of the province of Quebec. The provision of services in French is provincially directed by the *French Language Services Act*.⁶⁷ The Act guarantees an individual's right to receive services in French from Government of Ontario ministries and agencies in 26 designated areas. North Simcoe Muskoka is home to three of the 26 provincially designated areas, including Essa Township, Tiny Township and the Town of Penetanguishene. The *Patients First: Action Plan for Health Care* identifies the need to improve access by providing faster access to the right care.⁶⁸ The "right" care for the local Francophone population includes increased access to French language services.

Improved access to French language services requires concerted efforts by all major stakeholder groups, including LHINs, health service providers, health care professionals, political decision-makers, training institutions and communities. On December 8, 2015 the Ministry of Health and Long-Term Care renewed the mandate with the Francophone planning entity for North Simcoe Muskoka. This local French Language Health Planning Entity "Entité 4" plays a notable role in addressing the needs of the Francophone community. Over the past four years, the NSM LHIN and Entité 4 have maintained a strong working relationship and pursued joint initiatives that focus on four priority sectors including primary care, mental health and addiction, chronic disease and seniors.

Action Plans and Interventions

Action Plans and Interventions	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
1.5.1 Partner with Entité 4 to deliver on the Joint Action Plan and implement performance indicators on French language services linked to the plan.	In Progress	30	In Progress	30	In Progress	30
1.5.2 Encourage health service providers to collect data on patients' linguistic identity.	Not yet Started	25	In Progress	30	In Progress	40
1.5.3 Increase Francophone representation at local planning tables, including Specialized Geriatrics Services, Palliative Care, Mental Health and Addiction, and Home and Community Care.	In Progress	100				
1.5.4 Evaluate current service levels and assist in regional and local planning through the development and application of a standardized tool for French language services reporting.	In Progress	20	In Progress	30	In Progress	40
1.5.5 Develop a regional inventory to identify the need for and capacity of health service providers to deliver French language services.	Not yet Started	30	In Progress	30	In Progress	30
1.5.6 Support agencies seeking identification or designation to ensure they meet the required standards.	Ongoing		Ongoing		Ongoing	
1.5.7 Promote the implementation of and compliance with "Active Offer" guidelines.	In Progress	30	In Progress	30	In Progress	30

⁶⁷ Ontario, French Language Services Act, R.S.O. 1990, c. F.32

⁶⁸ Office of the Minister, Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Ministry of Health and Long-Term Care; 2015.

Measuring Success

- Increase number of health service providers collecting data related to clients identified as francophone
- Increase number of francophone representatives at local planning tables
- Increase number of identified agencies that complete the French Language Services Annual Report Survey
- Increase number of new health service providers that have achieved designation, partial designation or identification
- Increase number of health service providers that have implemented French language service "Active Offer" guidelines

Risks and Mitigation Strategies

Risks	Mitigation Strategy
▪ Challenges in recruiting and retaining adequate French speaking staff may impact access.	Reduce likelihood by assisting health service providers in recruitment efforts and promoting relationships between French speaking staff across agencies. Encourage health service providers to create learning opportunities for French speaking staff and promote designated and identified health service providers as employers of choice for French speaking health professionals.
▪ Health service providers are managing multiple competing priorities, which may impact resources dedicated to French language service requirements.	Reduce impact by encouraging participation of health service providers at the NSM FLS Community of Practice in order to improve the sharing of strategies and resources.
▪ Need to increase awareness of mechanisms to promote "Active Offer" of French language services.	Reduce likelihood by delivering "Active Offer" workshops and continuing to educate the health service providers on the need for linguistically appropriate services.

Key Enablers

NSM French Language Services Community of Practice – The NSM French Language Services Community of Practice is a group which consists of all NSM French language identified and designated health service providers in the region. The Community of Practice collaborates to share best practices, policies, resources, and lessons learned. In doing so, they enable the work of building and supporting French language services across the region. At the same time, the LHIN leverages the expertise of the group to overcome barriers and gaps which have been identified in an effort to assist in improving LHIN-wide service provision. The opportunity for the group to communicate across providers has enabled cross organizational collaboration and resource sharing to take place. Non-LHIN funded organizations are also represented, thereby ensuring greater cross-sector collaboration.

Community Engagement – Community engagement efforts will be increased over the coming fiscal year to enable the completion of LHIN deliverables in a manner that is both responsive to the needs of the community and patient-focused. A continued partnership with the French Language Health Planning Entity (Entité 4) is key in advancing the work to meet the needs of the Francophone community. Their primary role is to support the engagement of the Francophone population to solicit feedback regarding their health needs and priorities, health services available, and the potential identification of organizations for French language services. This input can then be used as the foundation for informed, evidence-based, patient-centred planning.

Goal 1.6: Improve access to culturally safe care for First Nations, Métis, and Inuit (FNMI) residents.

Consistency with Government Priorities

The *Local Health Services Integration Act (2006)*, mandates that LHINs recognize the role of First Nations and Aboriginal peoples in the planning and delivery of health services in their communities.⁶⁹ *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, reiterates this commitment to improve health equity and reduce health disparities.⁷⁰ The NSM LHIN initiatives align with the MOHLTC's ongoing commitment to the work of the Aboriginal Health and Wellness Strategy, and responding to critical service needs for First Nations, Métis, and Inuit (FNMI) communities in the region.

In November 2007, the Provincial Aboriginal LHIN Network created a shared community of practice for Aboriginal LHIN Leads across Ontario. The objectives of the network are to encourage communication across LHINs, and better understand the unique needs of each distinct Aboriginal community in each region. These networks further serve to facilitate knowledge transfer, share promising practices, engage and develop relationships with provincial and federal stakeholders, and increase awareness surrounding Aboriginal health priorities. Advancing cultural competency training, alignment with mental health and addiction, supporting Aboriginal engagement in diabetes, hospice palliative care planning, and supporting Aboriginal engagement in new personal support services (PSS) and home care policy implementation have all been identified through the network as provincial areas of focus.

Action Plans and Interventions

Action Plans and Interventions	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
1.6.1 Support health service providers to develop, implement and monitor self-identification policy.	Not yet Started	30	In Progress	30	In Progress	40
1.6.2 Develop a training plan to support the provision of cultural sensitivity training in health service provider organizations.	Not yet Started	100				
1.6.3 Support the work of the Aboriginal Health Circle in their proposal of a regional First Nation, Métis, and Inuit Residential Treatment Centre.	Ongoing		Ongoing		Ongoing	
1.6.4 Develop a plan to support CCAC and FNMI communities to work together to increase home and community support services in FNMI communities.	Not yet Started	100				
1.6.5 Support the Aboriginal Health Circle with data and information in the development of a plan to increase culturally appropriate long-term care services within FNMI communities.	In Progress	30	In Progress	30	In Progress	30
1.6.6 Increase FNMI representation at local planning tables, including Specialized Geriatrics Services, Palliative Care, Mental Health and Addiction, and Home and Community Care.	In Progress	100				
1.6.7 Support the implementation of the Aboriginal Health Circle objectives and deliverables of the LHIN's strategic priorities, in the context of improving the health status of the Aboriginal people.	In Progress	30	In Progress	30	In Progress	30

⁶⁹ Ontario, Local Health System Integration Act, 2006, S.O. 2006, c. 4.

⁷⁰ Ministry of Health and Long-Term Care. *Patients first: a proposal to strengthen patient-centred health care in Ontario*. MOHLTC; 2015.

Action Plans and Interventions	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
1.6.8 Deliver FNMI cultural sensitivity training for all health service providers sitting at local planning tables, all LHIN Staff and Board members.	In Progress	50	In Progress	40	In Progress	10

Measuring Success

- Increase number of health service provider agencies/organizations that have implemented a FNMI self-identification policy
- Increase number of health service providers who receive cultural sensitivity training
- Increase number of FNMI representatives at local planning tables

Risks and Mitigation Strategies

Risks	Mitigation Strategy
▪ Health service providers' level of knowledge and capacity may not be sufficient to provide culturally safe care and services to FNMI patients.	Build knowledge and capacity by continuing to partner with the Aboriginal Health Circle and supporting cultural safety training for health service providers.
▪ Complexity of potential funding mechanisms for residential treatment services involve various ministries as funding partners and can therefore be difficult to navigate.	Improve likelihood of accessing funding by investigating all alternate sources.
▪ FNMI patients may not be identified at intake points, as effective mechanisms may not be in place.	Reduce likelihood by implementing self-identification policy. Utilize technology to ensure the process is efficient.

Key Enablers

Provincial Aboriginal LHIN Network – The network supports the Aboriginal portfolio at the provincial level by encouraging cross-LHIN collaboration, knowledge transfer, and communication. The focus is on Aboriginal community engagement and pan-LHIN planning for an integrated health care system that meets the needs of local Aboriginal communities throughout Ontario.

Aboriginal Health Circle – The Aboriginal Health Circle works in partnership with the NSM LHIN to improve the health status of Aboriginal people in the NSM region. Engagement of the representatives of the FNMI community helps ensure that LHIN work continues to be informed by the needs and perspectives of the FNMI community.

LHIN Planning and Advisory Committees – Local planning tables bring partners together, which presents the opportunity to discuss how to identify need, and plan and implement strategies that ensure increased access to services for FNMI community members. These tables include Mental Health and Addiction, Seniors' Health, Integrated Networks of Care, Home and Community Capacity, Health Links Community of Practice, the North Simcoe Muskoka Hospice Palliative Care Network, and the Patient Family Caregiver Advisory Panel.

Aboriginal System and Health Links Coordinator – The Coordinator supports the region and the LHIN in identifying new opportunities and areas for system improvement which supports First Nation, Métis, and Inuit communities. The Coordinator acts as a key resource in championing local initiatives and engagement for the purposes of identifying regional gaps, needs, and successes. This role also supports education and community awareness of Health Links within their work to support individuals with FNMI specific care plans.



Integrated Health Services Plan Strategic Priority:

2.0 Build Capacity and Enhance Coordination

Description of the Priority

This Strategic Priority reflects the importance of building capacity to ensure that patients receive high quality, integrated care from providers across the continuum. Recent data indicates that the prevalence of chronic disease in NSM is the second highest in the province and the rate of multiple chronic conditions in this region is increasing over time. Given that people with chronic disease require care and services from multiple providers, highly coordinated care is important to improve outcomes for this population. Quality and coordination of care can be measured by hospital readmission rates, which are influenced by factors such as the quality of hospital care, care transition and coordination processes, and the availability and use of community resources. Alternate level of care (ALC) also remains a significant issue in North Simcoe Muskoka and reflects challenges in capacity and coordination across the continuum of care. Seniors aged 65 and older represent the majority of acute care patients designated as ALC, which is of particular importance given the projected rate of growth for the seniors population in North Simcoe Muskoka. In 2016/17, the NSM LHIN will focus its efforts on building capacity and enhancing coordination in the care of seniors and older adults, individuals with complex needs, and palliative care patients. Technology is also key enabler in improving coordination between providers and as such is a significant area of focus for 2016/17.

Current Status

Community Services for Seniors and Older Adults

There are a number of programs and services which specifically support seniors and older adults in NSM. Assisted Living Services for High Risk Seniors (ALS-HRS) is currently being delivered by Helping Hands and Independent Living Services of Simcoe County and Area, through funding provided to right-size and expand current ALS-HRS programs in targeted NSM regions. Although it is difficult to determine precisely how many local patients would be eligible for ALS-HRS services, it is estimated that approximately 635 individuals in NSM could potentially benefit from support from the program. To ensure services are available close to home, a local operational framework was developed which would require those providing services to high risk seniors to be within a 20 minute travel radius of patients. To ensure efficiency, this same radius must also include a minimum of 25 patients. This translated to three NSM communities having the critical mass to provide ALS-HRS services: Barrie, Orillia, and Collingwood. Moving forward, the regional ALS-HRS planning committee will plan to support the delivery/availability of ALS-HRS within all five NSM communities through integration and collaboration. The ALS-HRS program began in October 2015 and as of Q3 2015/16, has provided service to 82 individuals.

The delivery of personal support services for seniors is prioritized based on need, which challenges the capacity of the system to deliver services to individuals with lower needs. Seniors with lower needs are offered to be placed on the CCAC waitlist and are also provided information and/or referred to other community agencies for services. Significant collaboration will be required to increase capacity to provide services with existing resources, given that access is already a challenge for this population. The NSM LHIN is working with the current ALS-HRS providers, community referral organizations and the NSM CCAC to estimate the number of individuals by community who may benefit from in-home supports but are not currently being formally supported by the health care system.

In 2015/16, the NSM LHIN continued work on implementing an integrated regional seniors' health program. The initial focus has been on Specialized Geriatric Services (SGS), which includes community based mental health services intended to diagnose, treat, and rehabilitate frail seniors. In October 2015, Waypoint Centre for Mental Health Care was selected as the lead agency for SGS through a Request for Proposal (RFP) and subsequent

evaluation process. The process was also successful in highlighting the potential partnerships among other organizations and the generation of ideas which can be applied to the model being developed. In 2016/17, the focus for SGS will be to move forward in integrating the financial resources currently being distributed across multiple organizations. As the regional program matures, SGS will provide frail seniors with improved assessment, diagnostic and management supports thereby reducing alternate level of care (ALC) days, emergency room utilization, and hospital admissions.

Health Links

There are five Health Links in North Simcoe Muskoka, which cover each of the five NSM communities, including Barrie (Barrie Community Health Link), Orillia (Couchiching Community Health Link), Collingwood/Wasaga Beach (South Georgian Bay Community Health Link), Midland/Penetanguishene (North Simcoe Community Health Link), and Muskoka (Muskoka Community Health Link). In 2015/16, 480 Health Link patients were served, with continued growth anticipated for 2016/17 as the Health Links mature. Health Links have created partnerships across both funded and non-funded organizations. Each has a range of service providers formally committed to the partnership. The partners involved in each Health Link are as follows:

Table 4: Collaborations for NSM Health Links

Health Link	Partner Organizations	
Barrie Community Health Link (Barrie area)	▪ Barrie Community Health Centre ▪ Barrie and Community Family Health Team ▪ Royal Victoria Regional Health Centre ▪ Canadian Mental Health Association, Simcoe County Branch ▪ Independent Living Services of Simcoe County and Area ▪ NSM CCAC ▪ Barrie Food Bank ▪ Barrie and Area Native Advisory Circle ▪ Cara House ▪ County of Simcoe ▪ David Busby Centre ▪ Independent Retirement Home ▪ Royal Victoria Hospital Detox Centre ▪ Simcoe Muskoka District Health Unit	
Couchiching Community Health Link (Orillia area)	▪ Couchiching Family Health Team ▪ Orillia Soldiers' Memorial Hospital ▪ Canadian Mental Health Association, Simcoe County Branch ▪ Helping Hands ▪ Barrie and Area Native Advisory Circle ▪ NSM CCAC ▪ County of Simcoe ▪ Centre for Addiction and Mental Health (CAMH) STOP program ▪ Chippewas of Rama ▪ Enaahdig Healing Lodge and Learning Centre ▪ Georgian College ▪ North Simcoe Muskoka Hospice Palliative Care	
Muskoka Community Health Link (District Municipality of Muskoka)	▪ Algonquin Family Health Team ▪ Muskoka Family Health Team ▪ Muskoka Algonquin Healthcare ▪ North Muskoka Nurse Practitioner-Led Clinic ▪ Muskoka Health Hub ▪ The District Municipality of Muskoka ▪ Canadian Mental Health Association Muskoka Parry Sound Branch ▪ NSM CCAC ▪ Almaguin Highlands Health Center ▪ Muskoka Community Futures ▪ Muskoka Community Network ▪ Muskoka OPP ▪ Nipissing University ▪ Muskoka's Planning Tables, including Seniors' Services, Attainable Housing Advisory, Bridges out of Poverty, Transportation Committee etc. ▪ Canadian Mental Health Association, Muskoka Parry Sound ▪ Simcoe Muskoka District Health Unit ▪ Township of Georgian Bay ▪ Township of Muskoka Lakes ▪ Township of Lake of Bays ▪ Town of Bracebridge ▪ Town of Gravenhurst ▪ Town of Huntsville ▪ Wahta First Nation	
South Georgian Bay Community Health Link (Collingwood/Wasaga Beach area)	▪ Collingwood General and Marine Hospital ▪ South Georgian Bay Family Health Team ▪ Breaking Down Barriers ▪ Barrie and Area Native Advisory Circle ▪ NSM CCAC ▪ Breaking Down Barriers Independent Living Resource Centre ▪ Collingwood General & Marine Hospital and Foundation ▪ Community Connection/211 ▪ Georgian Triangle Housing Resource Centre ▪ Hospice Georgian Triangle ▪ Society of St. Vincent de Paul ▪ Sunset Manor Long-Term Care Home	

Table 4 Continued: Collaborations for NSM Health Link

Health Link	Partner Organizations
North Simcoe Community Health Link (Midland/ Penetanguishene area)	▪ North Simcoe Family Health Team ▪ Chigamik Community Health Centre ▪ Georgian Bay General Hospital ▪ Barrie and Area Native Advisory Circle ▪ NSM CCAC ▪ Askennonnia Seniors' Centre ▪ Barrie Area Native Advisory Circle ▪ Beausoleil Family Health Centre ▪ Behavioural Supports Ontario ▪ Canadian Index of Wellbeing ▪ County of Simcoe ▪ Georgian College ▪ La Cle d'la Baie ▪ The Guest House ▪ Waypoint Centre for Mental Health Care ▪ Wendat Community Programs

The Health Links have demonstrated that with improved communication and knowledge of system components, timeliness and quality of care can be improved for patients. In 2015/16, the LHIN supplemented funding provided by the province to enable the success of local Health Links in improving coordination of care for high-needs patients. To ensure the Health Links are achieving deliverables for the investment, the NSM LHIN has implemented accountability metrics above and beyond those required by the province.

While the intention of Health Links was to improve the coordination of care planning among care providers in the immediate circle of care, experience has demonstrated that the care required for many of these individuals extends far beyond the strict definition of health care and into prevention, emotional wellness, and outcomes related to the social determinants of health. The complex and chronic conditions of many Health Link patients are affected by access to food, housing, financial resources, transportation, and social networks. As such, the scope of services provided by any one of NSM's Health Links is much broader than primary care or traditional allied health. Individuals seen through any of the five Health Links also have the opportunity to secure access to housing and housing supports, transportation to appointments and social networking opportunities, food and nutrition programs, and chronic disease management programs.

Palliative Care

Hospice and palliative care services are delivered in NSM through a number of providers and services, including six palliative care teams in the region and three residential hospices located in Barrie (10 beds), Huntsville (5 beds) and Collingwood (6 beds). The 21 hospice beds in North Simcoe Muskoka represent 12.4% of the province's 260 MOHLTC-funded residential hospice beds. For NSM, this equates to approximately 4.4 beds per 100,000 population. This bed to population ratio is one of the highest among the fourteen LHINs.⁷¹

The community support sector and the NSM CCAC also provide hospice and palliative care services via home and community nursing and personal support services. The regional North Simcoe Muskoka Hospice Palliative Care Network (NSM HPCN) provides a 24-hour support line for health care providers, advanced symptom assessment for clients with complex palliative care needs, and educational opportunities for providers, volunteers and caregivers. Campbell House in Collingwood opened in 2014/15 and has significantly increased the capacity of the system to provide local residential hospice services. The recent focus of the NSM HPCN has been on enhancing palliative services provided by long-term care homes and retirement homes.

In 2010/11, approximately 47.6% of deaths in NSM occurred in acute care that could have been planned for elsewhere; 5.9% died in complex continuing care, 8.1% in the emergency department, 20.6% in long-term care and 17.8% with/without in-home support.⁷² During fiscal year 2014/15, 1,736 individuals in NSM received in-home and/or residential hospice services. Palliative care patients are more likely than other patients to be designated as ALC.

⁷¹ Bell D, Gillis K. Strengthening Ontario's end-of-life continuum: Advice regarding the role of residential hospices. Residential Hospices Working Group; 2015.

⁷² Ministry of Health and Long-Term Care. Analysis based on 2010/11 data extracted from the DAD, CCRS, NACRS, NRS, OMHRS, and RPDB. MOHLTC; 2012.

Specifically, 14.7% of palliative care patients in the province had at least one ALC day in 2010/11 compared to 5.4% in other patients; in NSM, 21.5% of palliative patients had at least one ALC day versus 6.6% in other patients.⁷³

Technological Integration

The NSM LHIN has worked to build a reputation as a provincial leader in many areas of eHealth and enabling technology. There are a relatively low number of different electronic health systems across the region. Only two hospital information systems are used across all six NSM hospital organizations comprising eight hospital sites. As of 2015, all hospitals in the region have an electronic hospital information system in place. Likewise, the systems used in primary care settings are relatively homogenous. Three Electronic Medical Record (EMR) systems are used by 379 primary care and 242 specialist physicians.⁷⁴ This translates to 73% of the region's primary care physicians, and 45% of the region's specialists connected to an EMR. These physicians benefit from all of the integration opportunities that accompany connectivity to a provincially approved EMR. The presence of an EMR is a significant enabler for improved communication and participation in other provincial electronic integration initiatives such as Hospital Report Manager (HRM) and Ontario Laboratory Information System (OLIS).

All hospitals within North Simcoe Muskoka are also live with Hospital Report Manager (HRM). With HRM live at all hospitals, initiatives such as eNotification, which is dependent on the HRM system as a prerequisite, can also be implemented equitably across the LHIN. Being ahead of the provincial curve, in terms of full implementation of HRM, paves the way for further technological integration. Over the upcoming years, the NSM LHIN will build upon these past successes to enable improved communication between providers for the purpose of high-quality clinical decision making and improved patient outcomes.

There have been a number of successes and local innovations in recent years with respect to eHealth in the NSM LHIN. The Collingwood/Wasaga community has implemented a Hospital-to-Family Health Team data sharing interface. This interface allows documents such as medication profiles and reports to be shared freely between the Health Information System (HIS) of the hospital and EMR of the Family Health Team and Community Health Centre. Data sharing through this interface maximizes quality and timeliness of information and enables effective and efficient clinical decision making. This community is home to the South Georgian Bay Community Health Link which has built upon their history of technical innovation and collaboration to develop a local solution for the electronic creation and sharing of coordinated care plans for the Health Link patients in the community. Ninety-five coordinated care plans (CCPs) were completed electronically using this local solution in 2015/16.

In the Barrie area, a primary care patient portal has been implemented in 2015/16 as another example of electronic integration at the local level. This portal is now accessible to over 37 physicians, 43 nurses, and 26 other clinicians, and 1,710 patients. There have been over 7,355 uses of the portal for the purpose of viewing data. It acts as a secure means for patients to access their medical records, book appointments, and communicate with their care team. The Barrie community is also aligned with the Barrie Community Health Link and is one of the three Health Links in NSM to begin participation in the provincial Care Coordination Tool (CCT) proof-of-concept in 2015/16. Alongside the Barrie Community Health Link, the North Simcoe Community Health Link, which represents the Midland/Penetanguishene community, and the Couchiching Community Health Link, which aligns with the Orillia community, both went live with the provincial CCT pilot. These three Health Links have since been actively creating, publishing, and sharing CCPs among members within the circle of care via the provincial CCT. As of the end of March 2016, 132 electronic CCPs have been authored and published electronically across these three Health Links.

⁷³ Ministry of Health and Long-Term Care. Analysis based on 2010/11 data extracted from the DAD. MOHLTC; 2012.

⁷⁴ Ontario MD. EMR adoption by LHIN: funded EMRs. Ontario MD; June 30, 2015.

Goal 2.1: Establish infrastructure to improve care for seniors and older adults.

Consistency with Government Priorities

Strengthening home and community care for the aging population is a key element of the provincial *Patients First: Action Plan for Health Care*.⁷⁵ It has been known for some time that work needs to continue in this area and the action plan is only one of the most recent provincial directives to improve care for this growing population. In 2011, the Ministry of Health and Long-Term Care (MOHLTC) approved the *Assisted Living Services for High Risk Seniors Policy*.⁷⁶ This policy updated and replaced the provisions of the *Assisted Living Services in Supportive Housing (ALSSH)* policy of 1994 with a focus on seniors. It aims to enable high risk seniors to remain safely at home with greater access to personal support and homemaking services and targets individuals whose needs cannot be efficiently met through scheduled support visits, but are not in the position of requiring admission to long-term care.

In 2012, Dr. Samir Sinha made 166 recommendations regarding seniors' health, ranging from wellness and housing to specialized geriatric services and end-of-life care in the *Living Longer, Living Well* report.⁷⁷ In 2013, the MOHLTC released a plan entitled *Independence, Activity and Good Health* which aligned with many of the recommendations in the *Living Longer Living Well* report.^{77,78} In 2014, a regulatory amendment to the *Home and Community Services Act, 1994* was enacted entitled "O. Reg. 386/99: Provision of Community Services."⁷⁹ This amendment extended eligibility criteria and service maximums for personal support services provided by approved community service agencies. This change allowed LHINs to fund the delivery of these services. Two provincial guidelines were developed in 2014 to address the implications of the regulatory amendment entitled: *Policy Guideline for Community Care Access Centre and Community Support Service Agency Collaborative Home and Community-Based Care Coordination* and *Policy Guideline Relating to the Delivery of Personal Support Services by Community Care Access Centres and Community Support Service Agencies*.^{80,81}

The NSM LHIN's broad range of activities relating to the provision of home and community care for the aging population are related to the expectations set in these policies, amendments, expert reports, and guidelines. Together these policies highlight the opportunity to strengthen services for low, moderate, and high risk seniors through the implementation of common standards, tools and processes, including assessment, intake, and measurement and management of wait times. Implementing positive change will result in improved quality of life for individuals and reduce acute care and emergency service utilization.

Action Plans and Interventions

Action Plans and Interventions		2016/17		2017/18		2018/19	
		Status	%	Status	%	Status	%
2.1.1	Plan for the delivery of Assisted Living Services for High Risk Seniors (ALS HRS) services in other NSM LHIN communities.	Not yet Started	100				
2.1.2	Develop a regional CSS / CCAC integration plan aligned with provincial standards and guidelines for PSS implementation.	In Progress	100				

⁷⁵ Office of the Minister, Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Ministry of Health and Long-Term Care; 2015.

⁷⁶ Ministry of Health and Long-Term Care. *Assisted living services for high risk seniors policy*, 2011. An updated supportive housing program for frail or cognitively impaired seniors. Ministry of Health and Long-Term Care; 2011.

⁷⁷ Sinha SK. *Living longer, living well*. Report submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a seniors strategy for Ontario. 2012.

⁷⁸ Ontario Seniors' Secretariat. *Independence, activity and good health*. Ontario's action plan for seniors. Queen's Printer for Ontario; 2013.

⁷⁹ Ontario, O. Reg. 386/99: Provision of Community Services under Home Care and Community Services Act, 1994, S.O. 1994, c. 26

⁸⁰ Ministry of Health and Long-Term Care. *Policy guideline for Community Care Access Centre and community support service agency collaborative home and community-based care coordination*. MOHLTC; 2014.

⁸¹ Ministry of Health and Long-Term Care. *Policy guideline relating to the delivery of personal support Services by Community Care Access Centres and community support service agencies*. MOHLTC; 2014.

2.1.3	Evaluate community capacity/ readiness for information sharing and central intake as part of the Home and Community Care Guideline implementation. Identify existing technology assets and opportunities for electronic integration including telemedicine and ONEmail.	In Progress	100		
2.1.4	Revise the integrated regional Seniors' Health Strategy, to include Specialized Geriatric Services, Low Needs Seniors and High Risk Seniors.	Not yet Started	100		
2.1.5	Evaluate targeted seniors' health programs to identify opportunities for improved efficiencies and outcomes.	In Progress	30	In Progress	30
2.1.6	Facilitate any integrations required for the establishment of central intake, triage, and navigation for the Specialized Geriatric Services Program including behaviours.	Not yet Started	75	In Progress	25
2.1.7	Reallocate and integrate any resources associated with the redesign of the Behavioural Support System in alignment with provincial Behavioural Supports Ontario initiatives.	In Progress	50	In Progress	25
2.1.8	Support the SGS lead agency in developing plans for clinical design, health human resources, technological integration, communication and community engagement.	Not yet Started	30	In progress	30
2.1.9	Monitor the implementation of the current Assess & Restore projects (Enhanced SMART; Geriatrics training in Convalescent Care) as a means of improving community capacity to support frail seniors.	In progress	100		
2.1.10	Develop an implementation plan to support the recommendations stemming from the provincial Regional Geriatric Program/ Specialized Geriatric Services review.	Not yet Started	50	In Progress	50
2.1.11	Develop an implementation plan to align with the provincial Dementia Strategy.	Not yet Started	50	In Progress	50

Measuring Success

- Increase number of Community IM/IT surveys completed by CSS agencies (target: 95%)
- Increase number of targeted seniors' programs evaluated
- Increase number of incremental attendances / visits for Assess & Restore
- Increase number of unique individuals served by Assess & Restore
- Increase number of clinicians trained through Geriatrics Training
- Decrease percentage of unplanned, less urgent ED visits within the first 30 days of discharge from hospital for Assess & Restore clients
- Decrease percentage of unplanned readmission to hospital within 30 days of discharge from hospital for Assess & Restore clients
- Decrease number of CTAS IV, V Emergency Department visits
- Decrease ALC to Convalescent Care Program (CCP)
- Decrease ALC to Long Term Care
- Decrease ALC Rate (MLAA Indicator)

Risks and Mitigation Strategies

Risks	Mitigation Strategy
Continued evolution of the home and community and primary care sectors, and provincial planning for palliative care could impact the organization and implementation of programs, and the delivery of existing services, which has the potential to impact stakeholder relationships.	Reduce likelihood through the development of a comprehensive, strategic and timely community engagement, communication, and change management strategy. Apply a phased approach to planning and implementation. Effective change management strategies will be required to ensure ongoing alignment with provincial directions and system stability. Local planning tables, with membership comprised of clinical and operational subject matter experts, will enable the work and mitigate risks by identifying operational amendments to meet needs within the context of provincial transformation.
Several geographic areas throughout NSM do not meet the critical mass population required within the regional ALS-HRS framework. Until ALS-HRS services are available within these areas, demand for long-term care or ALC rates could increase in these communities.	Reduce impact by planning ALS-HRS in smaller communities within the greater context of home and community programs. Include low needs and palliative care services to ensure opportunities are leveraged to integrate and increase equity across all sub-geographies. Engage service providers in this planning.
Inclusion of low needs seniors, a population that is not currently receiving funded personal support services, within the scope of services to be provided creates a risk to system capacity. Demand for services is already high without including this population within existing resources.	Reduce impact by increasing efficiency of the current system via integration and inter-agency collaboration. Optimize opportunities to build upon existing funding and human resources associated with other programs and services for seniors.
Existing agencies that do not qualify to deliver high or low needs services following implementation of these programs could face instability.	Reduce likelihood by clearly communicating guidelines and service expectations well in advance of implementation to allow agencies to plan for and manage change. This will allow organizations to adjust to requirements or make plans in the event that they do not qualify as a service provider for these populations following implementation.
Redesigning barriers such as health human resources could cause delays to planning and implementation of integrated seniors' programming.	Reduce likelihood by engaging stakeholders including seniors, caregivers, and health service providers in planning and implementation. Identify barriers throughout each planning and implementation phase to implement upstream strategies.
Redesign of existing programs and services could lead to loss of services and/or program strength for some organizations while being strengthened in others. The affected organizations could experience spin off effects to other programs in terms of service reduction or service quality.	Reduce likelihood by engaging stakeholders including seniors, caregivers, and health service providers in planning and implementation. Map programs as well as program strengths during planning to ensure that opportunities to leverage existing resources and lessons learned are maximized.
Implementing the SGS program may have resource reallocation implications that should be considered during planning.	Avoid risk via LHIN review and approval of all proposed changes that impact funding and service volumes for seniors programs and services through the implementation of SGS.

Key Enablers

ALS-HRS Steering Committee – Existing ALS-HRS steering committee will continue to support LHIN efforts to work through implementation of ALS-HRS services throughout the region. Existing strong relationships within Home and Community sector through Home and Community Capacity Project Team and Community Support Services Collaborative will better support effective communication and productive working relationships. Existing ALS-HRS service providers in Barrie and Orillia will be used to monitor the evaluative framework, as well as serve as guidance and support for delivery of ALS-HRS services by other providers and in other geographic areas.

Existing Collaboration between CCAC and Community – There are a number of existing champions in the community support sector who can facilitate further engagement and support for planning and implementation. Collaborative successes, such as the recent work by the CCAC and the community support sector on the initial implementation of ALS-HRS enables success by creating the foundation for further work.

Standardized Intake and Referral Processes – The CCAC is currently implementing a pilot standardized intake and referral process. This pilot is aligned with many of the requirements of the MOHLTC's Assisted Living Services for High Risk Seniors Policy. This work has resulted in organizations within the community support sector being able to receive referrals according to standardized eligibility criteria. These initial steps in clearly defining and standardizing eligibility is an enabler for comprehensive regional change moving forward.

Leadership & Governance – A lead agency for the Specialized Geriatric Services Program will co-lead planning and implementation with the NSM LHIN. To support planning and implementation, a leadership team is being established, as well as relevant strategic and operational committees. A LHIN Lead is designated for seniors' health and the LHIN Chief Operating Officer is providing direct oversight to the initiative. Progress related to planning and implementation will be reported to LHIN Leadership Council alongside several other key LHIN initiatives (Mental Health & Addiction, Integrated Networks of Care, In-Home & Community Capacity). Together, leaders from across the LHIN can monitor and support the coordination of planning to support ALC reduction and ensure the right patients are receiving the right care at the right time by the right providers.

Seniors' Health Project Team – The Project Team, as advisory to the LHIN and Specialized Geriatric Services Lead Agency, will be accountable for regional system recommendations and ensuring planning and implementation aligns with relevant project charter(s). Comprised of strategic leaders from within and outside the health sector, this team will use best evidence and system knowledge to inform recommendations that take into consideration the perspective of NSM seniors and their caregivers, health service providers, as well as the health system, including value for money.

Engagement & Communication – A comprehensive, strategic, and timely community engagement and communication plan will be a key enabler to success. With community engagement and communication resources dedicated specifically to this initiative and access to the Seniors Health Project Team, LHIN Leadership Council as well as individuals with lived experience, including the LHIN's Patient Caregiver Family Advisory Panel, will engage partners in planning and implementation. In addition, a Physician Lead for Seniors Health, as part of the Specialized Geriatric Services Program's leadership team, will promote physician engagement and support throughout planning and implementation.

Existing Resources – Many resources currently exist in the NSM system. In 2014/15, a review of thirteen targeted seniors' health programs highlighted successes and also identified opportunities related to efficiencies and outcomes through re-design. Leveraging these existing resources and the findings from the program will help support the development of an integrated regional seniors' health program. By building into planning resources generated through provincial initiatives like Assess & Restore, Convalescent Care expansion and Health Links, NSM can move towards the establishment of an integrated regional network of care.

Best Practices – Resources currently exist related to best practices that can be leveraged to expedite planning and implementation and optimize outcomes. Building relationships with existing Regional Geriatric Programs and Specialized Geriatric Service programs across the province and country can lead to strategic alliances and alignment. Leveraging best practices work like RAO Best Practice Guidelines, the RCA Compendium of Geriatric Syndromes, and work related to the provincial Senior Friendly Hospital initiative can support the implementation of standardized leading practices across the region.

Existing Shared Clinical Information Systems – Improving care for seniors within NSM will require an integrated and collaborative approach, supported and enabled through technology. Technology will serve to enable and improve the capacity of service providers across the sectors to communicate and share client information, as well as enhance and facilitate greater integration and collaboration. Improved access to client information, as well as increased ease in communicating within the circle of care will create an infrastructure that will serve to improve care for seniors in NSM.

Goal 2.2: Enhance coordinated care for individuals with complex needs.

Consistency with Government Priorities

Health Links serves patients by coordinating and connecting services as described in the *Patients First: Action Plan for Health Care*.⁸² Delivering more coordinated and better integrated care will ensure that the system is easier to navigate, and that the care received is more seamless and inclusive of perspectives across providers. This is especially important for those with multiple and complex health conditions who have numerous interactions with the system and account for the most significant proportion of health care expenditures. Health Links was developed to address the health needs of the 1-5% of the population that account for 66% of the total provincial health care expenditures. Health Links was designed provincially as a model which would improve access to primary and interdisciplinary care for these patients thereby decreasing negative health outcomes and hospital readmission rates, and decreasing emergency department visits for conditions that could be managed elsewhere. According to 2015/16 Q2 data provided by Health Quality Ontario, there is currently over 24,000 individuals with multiple and complex health conditions in NSM who may benefit from Health Links services.

Since Health Links were created, the model has been evolving and lessons have been learned both provincially and regionally. In alignment with the province, the NSM LHIN is moving towards the Advanced Health Links Model as a means of capitalizing on this knowledge. Each Health Link has been created and developed around the specific needs and circumstances of the community it serves. Now the opportunity exists to ensure equitable care across the region and the province by standardizing the definition of target populations, measurement, governance, and accountabilities. The NSM LHIN is actively aligned with the provincial work to increase accountability, target setting, and performance of the Health Links. NSM is also already actively working to broaden system integration by ensuring Health Links are a key component to work in other key areas of focus, such as primary care and home and community care.

Action Plans and Interventions

Action Plans and Interventions	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
2.2.1 Integrate Health Links into emergency departments (EDs) as a means of identifying appropriate patients and ensuring ED access to coordinated care plans (CCPs).	In Progress	75	In Progress	25		
2.2.2 Increase the number of complex patients who receive coordinated care through the NSM Health Links.	In Progress	100				
2.2.3 Develop a regional quality improvement plan which all five Health Links will monitor and measure.	Not yet Started	10	In Progress	40	In Progress	50
2.2.4 Develop a regional framework for Physician Assisted Death, in collaboration with system partners.	In Progress	33	In Progress	33	In Progress	33

Measuring Success

- Increase number of patients referred to a Health Link
- Increase number of individuals enrolled in a Health Link
- Decrease rate of emergency visits for conditions best managed elsewhere (MLAA Indicator)
- Decrease readmissions within 30 days for selected HBAM Inpatient Grouper (HIG) conditions (MLAA Indicator)

⁸² Office of the Minister, Ministry of Health and Long-Term Care. Patients first: action plan for health care. Ministry of Health and Long-Term Care; 2015.

Risks and Mitigation Strategies

Risks	Mitigation Strategy
▪ The complexity of patient needs may lead to a higher level of stress for some Health Link staff members, which may impact performance.	Reduce impact of stress on staff by providing support during Health Link Community of Practice meetings. Create safety mechanisms before the end of the fiscal year.
▪ Sustainability is a risk as the model evolves and referrals increase due to greater provider awareness of the Health Links. This will have an impact on the ability to serve patients in the future.	Reduce impact by continuing to emphasize savings to the system that are realized by improved health outcomes for high users. Facilitate discussion of innovative ways that HL functions can be incorporated in the core work of ongoing operations of host organizations.
▪ Muskoka Health Link is currently utilizing a secure interim solution for sharing the Coordinated Care Plans of Health Links patients between providers in their circle of care. Migrating to a permanent solution may require data migration and work process re-design.	The current interim solution used in Muskoka is not a sustainable solution and is also not currently accessible to providers outside the Muskoka community. Migration risks will be mitigated through a comprehensive project management approach.

Key Enablers

Collaboration with Municipalities, Public Health, and other non-LHIN funded organizations – Collaboration and partnership is a key enabler to successful coordinated care planning. While the Health Links have been very successful in establishing partnerships with health care organizations, opportunities remain to strengthen partnerships and the definition of common objectives with organizations outside of the narrow definition of health care. Key issues identified within the Health Links include mental health and addiction, social isolation, individuals being under-housed, lack of broader supports for those in supported housing, income and income supports, access to adequate and proper nutrition, and chronic conditions which have been poorly managed thus exacerbating illness. Since Health Link clients are so affected by the issues often outside the traditional scope of health care, these services such as supportive housing, nutrition, public health and income support need to become a more integrated part of the circle of care.

Enabling Technology – The ministry-delivered Care Coordination Tool (CCT) is an electronic version of the coordinated care plan (CCP) that was developed with input from clinicians and consultations involving LHINs, Health Links, and Health Quality Ontario. The implementation of technology-enabled care coordination solutions in Health Links is a critical enabler of coordination and the changes to service delivery that are necessary to improve care for patients with complex needs.

Goal 2.3: Strengthen collaborative planning for palliative care services.

Consistency with Government Priorities

The *Declaration of Partnership and Commitment to Action* that was provincially established in 2011 provides a common vision for palliative and end of life care in Ontario.⁸³ The goal is to support all those with progressive life-limiting illness and their families through the spectrum of care, enabling them to live as they choose with optimized quality of life, comfort, dignity and respect in a manner that is focused on quality care within a sustainable cost-effective context. More recently, the *Patients First: Action Plan for Health Care* focuses on providing care in home and community as both a more patient-centred and cost effective setting for care delivery.⁸⁴ The Auditor General's *Annual Report 2014* included a section on palliative care and emphasized that home-based palliative care services result in higher patient and caregiver satisfaction with end-of-life.⁸⁵

The provincial creation of the Ontario Palliative Care Network (OPCN), will strengthen palliative care in Ontario and continue to move the work of the previously established Hospice Palliative Care Provincial Steering Committee. Under this network, each LHIN will have a regional Palliative Care Program. The OPCN will work with the 14 regional Palliative Care Programs and will be accountable for quality improvement initiatives, data and performance measurement and the coordination of system level palliative care in Ontario. The OPCN will align palliative and end-of-life care standards with the Declaration, ensuring alignment of provincial and regional strategies with this guiding document. The NSM LHIN, working jointly with Cancer Care Ontario, will lead the development of the NSM Regional Palliative Care Network which will be responsible for planning a regional Palliative Care Program and supporting the alignment of local services and performance with provincial standards. The NSM LHIN has had a Hospice Palliative Care Network for a number of years, so the work of this group will be aligned to ensure provincial requirements are being met to advance the commitments of the *Declaration of Partnership and Commitment to Action*.⁸³

Action Plans and Interventions

Action Plans and Interventions	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
2.3.1 Collaborate with the Ontario Palliative Care Network to operationalize the provincial vision for palliative care.	In Progress	100				
2.3.2 Develop a North Simcoe Muskoka Regional Palliative Care Program in collaboration with Cancer Care Ontario and aligned with the OPCN.	In Progress	100				

Measuring Success

Initiatives will be measured via completion of the identified actions. Focus of planning to include improvement in the following areas:

- Increase number of individuals receiving residential hospice services
- Increase number of individuals receiving visiting hospice services
- Increase number of visits (for visiting hospice services)
- Increase number of hours of care for residential hospice services
- Increase number of hours of care for visiting hospice services
- Decrease ALC to palliative care

⁸³ Local Health Integration Networks and Quality Hospice Palliative Care Coalition of Ontario. Advancing high quality, high value palliative care in Ontario: declaration of partnership and commitment to action. Queen's Printer for Ontario; 2013.

⁸⁴ Office of the Minister, Ministry of Health and Long-Term Care. Patients first: action plan for health care. Ministry of Health and Long-Term Care; 2015.

⁸⁵ Auditor General of Ontario. Annual report 2014. Office of the Auditor General of Ontario; 2014.

Risks and Mitigation Strategies

Risks	Mitigation Strategy
Regional concerns about North Simcoe Muskoka's Hospice Palliative Care Network and any real and/or perceived conflicts of interest could disrupt working relationships within the new Regional Palliative Care Network.	Reduce impact via effective facilitation and management of all stakeholders involved in regional planning. Ensure there is opportunity to participate, share perspectives and lessons learned and provide feedback. Accountability to the LHIN and CCO will support greater accountability to the network and the community as a whole.
Joint accountability of the regional palliative care program to the LHIN and CCO could create confusion in reporting relationships and in working through processes/requests.	Reduce impact through communication and clarity regarding roles, reporting relationships and processes for communication will mitigate the potential for confusion caused with joint accountability.

Key Enablers

NSM Hospice Palliative Care Network – Within NSM, there is an existing NSM Hospice Palliative Care Network that includes regional stakeholders and providers. Existing relationships within this sector will support the productive working relationships required as the foundation for the creation of the NSM Regional Palliative Care Network.

Ontario Palliative Care Network (OPCN) – The Ontario Palliative Care Network (OPCN) will provide provincial oversight to support the implementation and alignment of local and regional palliative care programs. The work of the OPCN will also support provincial and regional alignment and standardized expectations for regional programs in the commitment to improving access and equity in palliative and end-of-life care at home and in the community. The OPCN will enable planning to be completed on a local level by ensuring coordination and standardization across regions from the provincial perspective.

Goal 2.4: Increase the level of electronic integration between providers.

Consistency with Government Priorities

Strengthening the level of electronic integration between providers at the local level is well aligned with all of the tenants of the *Patients First: Action Plan for Health Care*.⁸⁶ Streamlined information sharing and referrals make access more timely and appropriate, better integration connects providers, centralized information sharing facilitates clinicians ability to inform individuals about their needs and care plans, and leveraging technology means that this information sharing is done in the most efficient and sustainable manner possible, thereby protecting the health care system. The goal of sharing information more effectively is to improve patient care and outcomes through timelier access and better quality information for clinical decision making.

The primary purpose of the eHealth Strategy 2.0 is to ensure that eHealth investments advance the goals of the provincial *Patients First: Action Plan for Health Care*.⁸⁶ Associated with this strategy is eHealth Governance 2.0, which focuses on creating the conditions to develop and advance the eHealth strategy through ministry leadership in collaboration with key partners, and eHealth Privacy and Information Management 2.0, which includes strengthening health information privacy protection. The NSM LHIN's approach will continue to align with the provincial eHealth 2.0 initiative as it continues to evolve.

Aside from provincial initiatives specific to eHealth technology itself, there are a number of provincial policies and initiatives to which technology plays an enabling role. Connectivity between hospitals, specialists, primary care, and interdisciplinary care professionals is enabled by health information systems. It is also an enabler of provincial projects related to home and community care, mental health and addiction, Health Links, and other services for those with complex and chronic health needs. As such, eHealth is not only reflected within the strategic priority of collaboration but also to those relating to access, quality, and sustainability. The NSM LHIN will maximize the value and life of existing technical assets by reducing duplication, avoiding unnecessary replacement of systems, and enhancing access to electronic health information for care providers, as per the MOHLTC's rollout schedule and direction.

Action Plans and Interventions

Action Plans and Interventions		2016/17		2017/18		2018/19	
		Status	%	Status	%	Status	%
2.4.1	Increase integration and maximize the use of existing resources by communicating the provincial direction regarding Hospital Information Systems (HIS). Foster regional partnership opportunities, hub hospital leadership, and the re-use of existing HIS technology.	In Progress	100				
2.4.2	Increase communication between hospitals and physicians by working with OntarioMD and the NSM Primary Care Network to increase physician enrollment and adoption of Hospital Report Manager (HRM).	Not yet started	30	In Progress	30	In Progress	40
2.4.3	Monitor the adoption of electronic Coordinated Care Tools (CCTs) including issues, successes, and lessons learned. This includes the interim CCT locally developed by the South Gcfcceorgian Bay Health Link, the interim solution used by the Muskoka Health Link, and the three local Health Links piloting the provincial CCT.	In Progress	50	In Progress	50		

⁸⁶ Office of the Minister, Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Ministry of Health and Long-Term Care; 2015.

Action Plans and Interventions		2016/17		2017/18		2018/19	
		Status	%	Status	%	Status	%
2.4.4	Improve access to specialists via increased primary care participation in the provincial eConsult pilot. Promote implementation, adoption, and use of the OTNHub and eConsult in alignment with ministry direction.	Not yet Started	10	In Progress	30	In Progress	70
2.4.5	Liaise between eHealth Ontario local providers in the adoption of the electronic health record solution (ConnectingGTA/Connecting Ontario). Support the three additional sites planning to go live in terms of ensuring resources are in place and implementation is monitored.	In Progress	5	In Progress	20	In Progress	35
2.4.6	Increase efficiency and avoid repeat testing by facilitating the sharing of lab results via the Ontario Laboratory Information System (OLIS). Monitor OLIS implementation and adoption in three local hospitals.	In Progress	100				
2.4.7	Increase efficiency and avoid repeat testing by facilitating the sharing of diagnostic imaging results via Diagnostic Imaging (DI) Common Services. Monitor implementation at the two local hospitals identified as provincial DI pilot sites.	In Progress	100				
2.4.8	Increase communication by spreading the hospital implementation of eNotification. Engage CCAC and primary care to optimize the use of the eNotification data to support patient care following an ED visit, hospital admission or discharge.	In Progress	10	In Progress	50	In Progress	40
2.4.9	Evaluate the current state of local adoption and utilization of the Integrated Assessment Record (IAR). Establish baselines and define opportunities to improve local adoption and utilization going forward.	Not yet Started	100				
2.4.10	Implement an NSM eReferral solution to replace the existing paper based referral system for referrals made from hospital to: CCAC, Complex Continuing Care, long-term care, and rehabilitation services.	Not Yet Started	50	In Progress	50		

Measuring Success

- Increase percentage of Primary Care Providers live with HRM
- Increase percentage of Health Links patients with Coordinated Care Plans that are electronically enabled in an electronic Coordinated Care Tool (CCT).
- Increase number of clinicians using eConsult
- Increase number of eConsults between primary care and specialists
- Increase percentage of eConsults between primary care and specialists that did not result in a referral to specialist
- Increase number of contributing/viewing providers live with Connecting GTA/Ontario
- Increase number of viewing only providers live with Connecting GTA/Ontario
- Increase number of hospitals live on OLIS
- Increase number of primary care providers live with OLIS
- Increase number of hospitals live with DI Common Services as viewers
- Increase number of primary care providers live with DI Common Services
- Increase number of hospitals live with eNotification
- Increase number of HSPs that uploaded data to the IAR

- Increase number of views of IARs per provider
- Increase number of hospital sites sending referrals electronically to CCAC, CCC, LTC and Rehabilitation via the regional eReferral solution.
- Increase number of referrals received via the regional electronic solution during a quarter (for each of 4 pathways: CCAC, CCC, LTC and Rehabilitation)
- Decrease average number of days between referral receipt to the date the referral was made to provider across all referrals received during a quarter (for each of 4 pathways)
- Increase percentage of patients receiving 7 day follow-up post discharge from acute care
- Decrease readmissions within 30 days for selected HBAM Inpatient Grouper (HIG) conditions (MLAA Indicator)

Risks and Mitigation Strategies

Risks	Mitigation Strategy
▪ Health service provider resource capacity to implement.	Reduce likelihood by working closely with health service providers around scheduling and resource effort.
▪ Continuous evolution and improvement related to enabling technology can lead to change fatigue among providers. This fatigue can create a risk to the level of clinician engagement and system adoption as new projects are initiated.	Reduce likelihood through effective community engagement and change management.

Key Enablers

Project Management Methodology, Tools and Techniques – Use of project management methodology to implement the projects identified in the action plans above will increase the likelihood of achieving successful project outcomes and completing projects on time, on budget, and within scope. NSM LHIN's Eclipse project portfolio management tool will enable a consistent approach to project management, tracking, and reporting.

Health Service Provider (Stakeholder) Engagement – Change management is a key success factor for any project. In health care, the identification of key stakeholders and early involvement of stakeholders is especially crucial to the success of the project. Transparent, clear, and concise communication with health service providers and stakeholders, clearly identifying the benefits for patient and care provider will result in better awareness of the project and increased adoption of the intended solution contributing to the overall success of the project.

Local System Consistency: The relatively low number of disparate Health Information Systems and Electronic Medical Record Systems across the LHIN puts NSM in a favorable position to be early adopters and innovators of eHealth initiatives. This potential has been demonstrated in the past when NSM LHIN was selected to be the pilot for the provincial e-Prescribing and Hospital Report Manager initiatives with very successful outcomes.

Central Ontario LHIN Cluster Project Management Office (PMO) – The Central Ontario LHIN Cluster PMO provides the six Central Ontario LHINs including North Simcoe Muskoka, with a project controller function, project management best practices, tools to coordinate efforts, and a standardized project reporting tool for consistency. This structure enables local project success by supporting alignment at the cross regional and provincial level. It is also a vehicle for sharing best practices, lessons learned, and innovation across regions.

NSM LHIN eHealth Advisory Committee – The newly formed eHealth Advisory Committee assists the LHIN in achieving its Annual Business Plan goals by acting as a central point of contact and a centre of excellence for information management and information technology. The committee will support the development of community-level plans built on the plans of each organization. It will act as a means for knowledge sharing, needs assessment, and gap identification. The committee will advise the NSM LHIN on eHealth and matters related to information technology and information management.

NSM LHIN Clinical Planning Tables and Primary Care Network – There are a number of planning tables, councils and project steering committees that collaborate across organizations with regards to specific topics or clinical disciplines. Regional planning groups include mental health and addiction, vascular, renal, palliative, home and community, community services, health system funding reform, stroke, cardiac, Aboriginal health, ophthalmology, emergency department, critical care, and primary care as examples. Each of these groups have LHIN staff associated with them and it is the linkages with these groups which can be leveraged to identify gaps and opportunities with regards to electronic integration and areas where technology can enable the achievement of their respective deliverables. The primary care network will be a group that can be engaged to enable the increased adoption of Hospital Report Manager among physicians in the region.



3.0 Drive System Sustainability

Description of the Priority

This Strategic Priority reflects the NSM LHIN's imperative to promote system sustainability, including efficient use of system resources, return on investment, and accountability for results. The provincial health care system faces a significant challenge as historic levels of investment are not considered sustainable. Health care expenditures currently account for approximately 42% of the provincial budget and without significant change are projected to represent 70% of spending within the next 12 years.⁸⁷ Contributing to this challenge is the shift in demographics towards an increasing seniors population, which will result in higher costs to the system. It is therefore necessary that resources are best utilized to ensure that NSM residents continue to receive appropriate care in the future. In 2016/17, the NSM LHIN will be working towards specific improvements in the acute care and long-term care sectors, as well as improving oversight and accountability for existing investments, and increasing transparency in directing future investments across all sectors.

Current Status

Quality in Acute Care

As of fiscal 2015/16, eighteen Quality Based Procedures (QBP) have been implemented. In NSM in 2015/16, \$13.1 million in funding was allocated to elective QBPs, which include procedures such as hip and knee replacements, cataract surgery, and tonsillectomies. During the same year, 33.6 million was allocated to non-elective QBPs. Non-elective QBPs usually involve admission to hospital for issues including COPD, CHF, stroke, neonatal jaundice, hip fractures or pneumonia. The volume is the number of these procedures or cases that were completed via this funding allocation. Table 5 provides a breakdown of NSM's funded cases for 2015/16.

Table 5 – NSM LHIN – Hospital QBP 2015/16 funded cases

NSM LHIN QBP Allocation:	Volume	\$\$
Elective QBPs		
Acute Inpatient Knee Arthroscopy	1163	\$1,831,770
Acute Inpatient Primary Bilateral Joint Replacement	6	\$79,919
Acute Inpatient Primary Unilateral HIP Replacement	390	\$3,539,681
Acute Inpatient Primary Unilateral KNEE Replacement	634	\$4,978,685
Acute Inpatient Tonsillectomy	579	\$746,589
Rehab Inpatient Primary Unilateral HIP Replacement	12	\$64,622
Rehab Inpatient Primary Unilateral KNEE Replacement	4	\$10,471
Unilateral Cataract Day Surgery	3736	\$1,871,130
Elective QBPs Total	6524	\$13,122,869
Non-Elective QBPs		
Acute Inpatient Chronic Obstructive Pulmonary Disease (COPD)	1152	\$9,092,853
Acute Inpatient Congestive Heart Failure (CHF)	815	\$6,602,316
Acute Inpatient Hip Fracture	612	\$5,970,673
Acute Inpatient Neonatal Jaundice	138	\$386,440

⁸⁷ Ministry of Health and Long-Term Care. Health system transformation: a year in review. Presented at Ontario Hospital Association Health Care Financial Management Conference; 2015.

Table 5 Continued – NSM LHIN – Hospital QBP 2015/16 funded cases

NSM LHIN QBP Allocation:	Volume	\$\$
Non-Elective QBPs (Continued)		
Acute Inpatient Pneumonia	620	\$4,508,930
Acute Inpatient Stroke Hemorrhage	57	\$474,386
Acute Inpatient Stroke Ischemic Or Unspecified	445	\$3,819,274
Acute Inpatient Stroke Transient Ischemic Attack (TIA)	150	\$598,526
Non-Elective QBPs Total	3989	\$31,453,399
Non-Cardiac Vascular QBPs		
Acute Inpatient Non-Cardiac Vascular Aortic Aneurysm (AA) excluding Advanced Pathway	65	\$1,291,837
Acute Inpatient Non-Cardiac Vascular Lower Extremity Occlusive Disease (LEOD)	113	\$850,722
Non-Cardiac Vascular QBPs Total	178	\$2,142,558
Grand Total	10691	\$46,718,826

Long-Term Care

There are currently 26 long-term care homes in operation in North Simcoe Muskoka, including fifteen for-profit homes, seven not-for-profit homes, and four homes that are municipally operated. These 26 homes are funded for 2,975 long stay beds in total, distributed across the NSM LHIN as follows:

Table 5: Long-Term Care Home Beds by NSM LHIN Sub-geography

	# of Beds	# Homes
Barrie and area	1126	10
Orillia and area	519	4
Collingwood and area	412	5
Midland / Penetanguishene and area	408	3
Muskoka	510	4
Total	2975	26

Current wait list data indicates that there are significantly more people waiting for long-term care placement in NSM than there are beds to accommodate. For example, in the Barrie area, the wait list for placement is approximately double the number of funded beds in that community. The wait list numbers for basic accommodations significantly exceeds those for either semi-private or private rooms for most facilities.⁸⁸ MOHLTC stipulations dictate that LTC homes are permitted to have up to 60% private/semi-private accommodation in a given year. However, approximately 70% of current requests for long-term care beds in NSM are for basic accommodation, which only lengthens the wait time to placement. This allowance is outside of the scope of the LHIN, and therefore poses a constraint on local efforts aimed at wait list reduction. Wait lists are also impacted by the growing seniors population in NSM and by the increasing medical needs of this population.

In late June 2015, the North Simcoe Muskoka LHIN was informed that MOHLTC's Nurse Practitioners in Long-Term Care Homes initiative would be moving forward. Nurse Practitioners funded through the initiative will provide on-site primary care for residents of long-term care, including screening and assessment, chronic disease management, specialist referral, and end-of-life care, as well as providing leadership and education to LTCH staff. This initiative is expected to improve coordination and quality of care for residents, as well as reduce the need for transfer to acute care. Creedan Valley Care Community (Creemore) in collaboration with Owen Hill Care Community (Barrie), and Woods Park Care Centre (Barrie) were the successful recipients of this initiative funding.

⁸⁸ NSM CCAC; North Simcoe Muskoka long-term care home wait time report. NSM CCAC; November 2015.

Goal 3.1: Enhance quality and efficiency in the acute care system.

Consistency with Government Priorities

Health System Funding Reform (HSFR) is a key lever to incent providers to move forward in supporting the realization of the *Patients First: Action Plan for Health Care*.⁸⁹ It is grounded in many of the same principles including access, integration, quality, and sustainability in the provision of patient-centred care and the optimization of health outcomes. The work completed at the regional level is in support of the continued implementation of Health System Funding Reform. Strategic investments are made by the LHIN to promote future HSFR funding for the NSM region, thereby improving access to care, quality and standardization. Initiatives to improve care and therefore optimize HSFR funding are planned collaboratively, implemented by service providers, and approved and monitored by the LHIN. Local implementation of HSFR enables all regions to move toward a more equitable and evidence-based approach to funding, which is designed to be responsive to the health care needs of the population.

Due to the nature of the HSFR model, there is an inherent alignment of the LHIN work with the priorities of the province. As part of the initiation of HSFR, the MOHLTC required the creation of a Health System Funding Reform Local Partnership within each LHIN. The Local Partnership acts as an advisory committee whose role is to support HSFR implementation and change management. Close collaboration between the LHIN and health service providers allows clinical and financial risks to be identified, potential outcomes to be reviewed and any required mitigation strategies to be developed collaboratively and at the local level.

Action Plans and Interventions

Action Plans and Interventions		2016/17		2017/18		2018/19	
		Status	%	Status	%	Status	%
3.1.1	Measure the level of implementation of Quality Based Procedures in NSM hospitals using the QBP Implementation Index. Use results to identify potential areas where collaborative action could create efficiency and improve performance.	In Progress	100				
3.1.2	Establish a formal process to request and review quarterly hospital reports identifying expected patient volumes measured against funded volumes. Use data collected to be proactive in optimizing the use of existing resources and ensuring equity in outcomes for patients.	In Progress	100				
3.1.3	Develop hospital specific scorecards which enable the LHIN as funding stewards to be effective in accurately monitoring funding as it relates to outcome achievement.	In Progress	100				
3.1.4	Streamline the system for tracking all funding distributed. Communicate this information across LHIN operations in an accessible and timely way. Allocations displayed by year, clinical area, sub-geography or program relationship will support planning and oversight.	In Progress	100				
3.1.5	Develop and implement a standardized electronic Staff Credentialing system across the five hospitals that currently have no electronic solution in place.	In Progress	100				
3.1.6	Monitor the implementation of standardized electronic triage (e-CTAS) in local Emergency Departments and any changes in patient volumes that may be related to the implementation of the electronic system.	Not yet Started	30	In Progress	30	In Progress	40

⁸⁹ Office of the Minister, Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Ministry of Health and Long-Term Care; 2015.

Measuring Success

- Increase score across hospitals according to the QBP Implementation Index
- Decrease \$ variance between Actual and Expected Cost per Weighted Case for QBPs
- Increase number of acute care providers that have achieved elective QBP volumes
- Increase number of acute care providers that have achieved non-elective QBP volumes
- Increase number of hospitals implementing an electronic solution for staff credentialing
- Increase percentage of staff credentialed via the electronic credentialing solution who were previously credentialed via a manual system
- Increase number of NSM hospitals initiating e-CTAS
- Increase number of providers forecasting a total margin >\$0
- Increase percentage of priority 2, 3, 4 cases completed within access targets for joint replacements (MLAA Indicator)

Risks and Mitigation Strategies

Risks	Mitigation Strategy
▪ Data quality is critical to ensuring the achievement of patient outcomes. The LHIN is dependent on the accuracy of service provider data which creates a risk to achieving desired outcomes. Data that is coded incorrectly or comes with errors due to manual input can affect analysis and decision making. Data entry is labour intensive for providers, which creates a risk to quality as a result of time and resource constraints. This risk is lower at the leadership level because there is a more intimate understanding of how data drives the funding structure.	Mitigate the risk by continuing to communicate the importance of data quality at the regional level. Facilitate local data quality committees and encourage service provider participation in ongoing training sessions or data blitzes delivered by the MOHLTC, the Ontario Hospital Association, and Canadian Institute for Health Information (CIHI). Engage providers at all levels to clearly communicate the correlation between data quality, effective regional planning and patient health outcomes. It is essential to ensure service providers including front line staff understand the value of high quality data.
▪ Data analysis is not automated within the LHIN. Planning, performance, and finance staff manually extract the data from provincial databases or local quarterly reports submitted to the LHIN. This data is then manipulated to produce the reports needed for informing decision making. The manual manipulation and aggregation of data does leave some risk for error.	Mitigate the risk by applying internal controls, attention to detail and subject matter expertise in mining provincial data repositories and exporting data from quarterly reports. Trend analysis and quarterly comparators will be employed to determine reasonability of the data and ensure that variation between data sets can be explained and not an indication user error.
▪ Patient needs are constantly changing. Continuous change means that issues demonstrated in one data set may not be relevant at the time the data is being viewed. This creates a risk that planning is based on data that no longer represents the current state.	Mitigate risk by building flexibility into planning and continually focusing on the future needs of the patient. Facilitate the inclusion of subject matter expertise in providing context from multiple perspectives including the clinical lens. Stakeholder engagement and subject matter expertise will help inform where the data may be changing at a practice level or where evaluation has evolved. Ensuring data is timely also supports decisions being made based on the most recent evidence available.

Key Enablers

Health System Funding Reform Local Partnership (HSFR LP) – The province has mandated the creation of a HSFR LP. To assist with capacity planning and change management around Health System Funding Reform, the LHINs have formed Local Partnerships that include representation from hospitals, the CCAC, and long-term care. NSM's HSFR Local Partnership has been working collaboratively since January 2013 to implement Quality Based Procedures at the local level. The group informs the distribution of resources, shares best practices, and identifies models of care, including care paths, policies and procedures to implement at an organizational level to meet provincial standards. The local partnership uses the results of the QBP Implementation Index to inform their work.

NSM LHIN Clinical Planning Tables – There are a number of planning tables, councils, and project steering committees that collaborate across organizations with regards to a specific topic or clinical disciplines. Planning groups across the region include mental health and addiction, vascular, stroke, cardiac, ophthalmology, emergency department, critical care, renal, palliative, home and community as examples. Many of these groups have LHIN staff associated with them and linkages with these groups can be leveraged to identify gaps and opportunities with regards to improving quality and maximizing the use of available funding to meet the needs within the community.

Goal 3.2: Improve quality and safety in long-term care.

Consistency with Government Priorities

The *Patients First: Action Plan for Health Care* acknowledges long-term care as a critical contributor to ensuring individuals get access to the right care, at the right time, and in the right place.⁹⁰ With respect to the aging population, it is essential that the North Simcoe Muskoka LHIN continues to support and enhance quality and safety for residents in long-term care. Two important strategies aimed at facilitating this are the *Enhanced Long-Term Care Home Renewal Strategy*, and the provincial initiative supporting *Nurse Practitioners in Long-Term Care Homes*.^{91,92}

The *Enhanced Long-Term Care Home Renewal Strategy*, announced in October 2014 by the Associate Minister of Health and Long-Term Care (Long-Term Care and Wellness), is designed to enable the redevelopment of approximately 30,000 beds in over 300 long-term care homes provincially by 2025. This initiative includes the redevelopment of 900 beds across twelve long-term care homes in North Simcoe Muskoka. This redevelopment will improve resident accommodations by bringing the homes up to the highest current design standard. Improved design standards will ensure greater safety for residents, while meeting current practice standards for long-term care home environments. This means moving closer towards a “home-like” space and moving further away from the notion of institutionalized care. The primary role of the LHIN in aligning with and supporting this provincial initiative will be to analyze the need for long-term care beds at the regional and community level and to support the equitable distribution of these long-term care beds in the future state.

The *Nurse Practitioners in Long-Term Care Homes* initiative, announced provincially in the summer of 2015, aims to provide funding for up to 75 new nurse practitioners within long-term care homes over three years.⁹² Thirty of these nurse practitioners were announced in September of 2015. As part of this initiative, funding for two full-time equivalent nurse practitioners was awarded to NSM LHIN. These positions will be integral to supporting quality care and safety within these environments. The role of these NPs will be to provide comprehensive resident care with the goal of reducing avoidable emergency department visits and improving health outcomes through the provision of clinical support and care coordination. The provincial provision of funding for nurse practitioners will further align with the LHIN's efforts to increase capacity within long-term care by utilizing these resources to not only provide direct resident care but education and leadership to internal staff.

Action Plans and Interventions

Action Plans and Interventions	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
3.2.1 Review applications as submitted by redeveloping long-term care homes and provide endorsement or feedback, as applicable.	In Progress	10	In Progress	10	In Progress	10
3.2.2 Continue analysis of the need for long-term care beds at the regional and community level to support redevelopment planning.	Ongoing					
3.2.3 Support long-term care home operators and the Ministry of Health and Long-Term Care to facilitate the redevelopment of 900 LTC beds across 12 long-term care in the region. (Completion date 2025).	In Progress	10	In Progress	10	In Progress	10

⁹⁰ Office of the Minister, Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Ministry of Health and Long-Term Care; 2015.

⁹¹ Ministry of Health and Long-Term Care. *Enhanced long-term care home renewal strategy*. MOHLTC; 2014.

⁹² Ministry of Health and Long-Term Care. *Nurse practitioners in long-term care homes*. MOHLTC; 2015.

Action Plans and Interventions	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
3.2.4 Oversee capital planning process for long-term care homes that have the acceptance of the MOHLTC into the Enhanced Long-Term Care Renewal Strategy.	Not yet Started	5	In Progress	10	In Progress	10
3.2.5 In accordance with MOHLTC requirements, establish accountability indicators for the Nurse Practitioners in Long-Term Care Homes initiative and monitor quarterly performance.	Not yet Started	100				
3.2.6 Engage with long-term care homes with regards to Information Management/Information Technology assets and accountabilities. Identify existing technology assets and evaluate opportunities to increase clinical adoption of Telemedicine.	Not yet Started	100				

Measuring Success

- Increase number of LTC homes that have received communication on the 2016/17 provincial eHealth priorities
- Increase number of LTC homes that have provided feedback on existing technology assets and needs
- Increase number of clinical telemedicine events per telemedicine unit allocated to long term care

Risks and Mitigation Strategies

Risks	Mitigation Strategy
▪ There are no new net long-term care beds available provincially, which may pose a challenge for facilities eligible to redevelop in that they must rely on current system capacity to do so.	Mitigate risk by working collaboratively with redeveloping long-term care homes to ensure a systems approach to planning is achieved, and to support a sustainable system that protects client safety and improved outcomes. Accept risk - NSM LHIN and the MOHLTC have clearly communicated that there are no new net funds available. It is critical that NSM LHIN continue open communications with operators and the MOHLTC to facilitate planning and movement for NSM LHIN. The NSM LHIN will continue to work collaboratively with the ministry to review redevelopment plans to ensure that local needs are being considered as redevelopment moves forward.
▪ The redevelopment plans of long-term care homes as submitted may not align with the needs of a LHIN. The interest of each long-term care home to protect their own resources at times can create a risk or disincentive for homes to plan collaboratively with the needs of the population as a whole within the community.	Avoid risk by ensuring LHIN oversight of the planning submissions of the local long-term care homes. Ensure that each have considered the needs of the broad community beyond their own specific interests as a requirement for LHIN proposal endorsement. This risk will be further mitigated by collaborative planning meetings or sessions involving all operators, and facilitated or supported by the LHIN. The LHIN will encourage information sharing and facilitate discussions amongst long-term care homes when issues are present. The NSM LHIN will continue to work collaboratively with the ministry to review redevelopment plans to ensure that local needs are being considered as redevelopment moves forward.

Key Enablers

Ministry of Health and Long-Term Care, Long-Term Care Renewal Branch – The MOHLTC has created a Long-Term Care Renewal Branch to support long-term care home redevelopment. Individual project managers have been assigned to long-term care homes requiring redevelopment, and LHINs will work closely with these project managers to support movement and ensure a collaborative approach to planning. The NSM LHIN has reviewed all twelve long-term care home redevelopment submissions made to the MOHLTC and is working with individual homes to understand their needs and assist with a system approach to planning.

Goal 3.3: Enhance transparency in planning and directing future investments.

Consistency with Government Priorities

Increasing LHIN capacity to strategically plan future investments is strongly aligned with the *Patients First: Action Plan for Health Care* in terms of ensuring sustainability and protecting the system for future generations.⁹³

Efficiencies are realized through higher quality and more timely decision making. Optimizing the use of existing resources including both human resources and technology resources relating to data, analytics, and decision support helps to create efficiencies and better value for money. Integrated data and decision support facilitates a better understanding of care patterns and improved coordination of care for patients. The upstream effect on the system relates to how shared data and decision support creates a greater capacity to plan appropriate care at the right time in the right place for patients. This in turn improves health outcomes and reduces costs for health care provision.

The mandate of the LHIN to plan, integrate, evaluate, and engage the community is supported by a number of provincial best practices to support planning and decision making. Best practices for community engagement and quality improvement also drive and enable the work at the LHIN level. These include, as examples, the pan-LHIN Decision Making Framework, the Health System Improvement Process (HSIP), the Joint Review Framework for capital planning, the LHIN Community Engagement Tool Kit, and the LHIN Physician Engagement Tool Kit. Each of these resources, developed at the provincial level, create a regional standard for work and provide a foundation to be customized as appropriate to the community needs, goals, and processes of the NSM LHIN. Tools developed by provincial agencies such as Health Quality Ontario, The College of Physicians and Surgeons, the Ontario Medical Association, the Ontario Hospital Association, the Ontario Long Term Care Association, the Ontario Association of Community Care Access Centres, the Association of Ontario Health Centers, and the Ontario Telemedicine Network are also provincial resources to which the NSM aligns local planning and investment for the purposes of system improvement and better patient outcomes.

Action Plans and Interventions

Action Plans and Interventions	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
3.3.1 Develop a system-wide approach to capital planning across the region.	In Progress	100				
3.3.2 Update the Health System Improvement Process and Q3 reallocation process for changes to the health system and new funding requests. Create updated instruction materials to ensure transparency of the process for stakeholders.	In Progress	100				
3.3.3 Integrate services into a single funding envelope for the Specialized Geriatrics Services program to maximize efficiency and effectiveness.	In Progress	30	In Progress	40	In Progress	30
3.3.4 Propose a Regional Decision Support Framework that clarifies the roles of the LHIN and system partners (e.g. health service providers and other stakeholders) in addressing availability, provision, and access to data for system level decision making.	In Progress	100				

⁹³ Office of the Minister, Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Ministry of Health and Long-Term Care; 2015.

Measuring Success

- Increase percentage of organizations that submit a Health System Improvement Proposal utilizing the proper HSIP process
- Increase number of agencies whose programming/funding has been integrated into the Specialized Geriatric Services funding envelope
- Increase funding aligned with single funding envelope for Specialized Geriatric Services

Risks and Mitigation Strategies

Risks	Mitigation Strategy
▪ Resistance from stakeholders to implement approved Regional Decision Support model.	Reduce likelihood through consultation with stakeholders and identification of potential risks, constraints, and lessons learned to be included in project charter.
▪ Resource availability could be identified as a constraint to the consideration or implementation of shared decision support across organizations.	Reduce impact by facilitating innovative thinking across organizations, utilizing and building upon existing resources as much as possible.

Key Enablers

LHIN Communications and Community Engagement – The input, feedback, and context obtained as the products of community engagement are used to inform operational processes of the LHIN. It is part of the LHIN's role to ensure planning is responsive to the needs of the community, residents, patients, informal caregivers, health service providers, and other stakeholders. As local processes for planning and decision making evolve and are improved, effective communication is essential to ensure that all health service providers have access to the same information and are clear about LHIN processes, requirements, and expectations. Stakeholder and community engagement in partnership with effective communication increases LHIN accountability to the community and ensures that processes are transparent and equitable.

Collaboration and Sharing of Existing Technology Resources – Members of the Health Services Funding Reform Local Partnership are among the service providers who have signaled the willingness and need for a collaborative working group focused on decision support. This group will explore existing capacity and identify gaps and opportunities to more effectively use data to make decisions. In these discussions, a number of community partners have identified a readiness to share the technology infrastructures for decision support that, if required, could enable the achievement of shared goals.

Goal 3.4: Strengthen accountability, oversight and monitoring of existing investments.

Consistency with Government Priorities

It is estimated that the cost of mental illness and addiction to Ontario's economy is roughly 38.1 billion dollars annually. As such, mental health and addiction is a key area of focus at the provincial level. Strengthening accountability and evidence based planning in mental health and addiction aligns not only with Ontario's strategy outlined in the *Patients First: Action Plan for Health Care*, but also with the *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*.^{94,95} More specifically, this goal directly aligns with the key objectives of "protect" as outlined in the *Patients First: Action Plan for Health Care*, as well as Pillar 5 of *Open Minds Healthy Minds*, by seeking to make decisions based on value and quality to ensure system sustainability.^{94,95} This goal also aligns with the strategic priorities of the newly formed Provincial Leadership Advisory Council and more specifically, their core objective of community funding reform.

Beyond strengthened accountability in mental health and addition, there are a number of areas and programs identified by the LHIN in which re-evaluation is necessary. Many of these are relatively new projects and now that they are fully implemented, it becomes prudent to look back at the achieved deliverables compared to planned outcomes and assess value in the current state. As necessary, revised or updated requirements for these programs can be communicated to service providers thereby further strengthening LHIN oversight and accountability. Taken together, strong oversight, continued monitoring, and evidence based planning in all areas will ensure existing and new funding is best directed based on need, quality, and evidence of achieving intended outcomes.

Action Plans and Interventions

Action Plans and Interventions		2016/17		2017/18		2018/19	
		Status	%	Status	%	Status	%
3.4.1	Review and revise indicators for Phase 1 and Phase 2 mental health and addiction funding as needed. Refine the process for monitoring and reporting.	In Progress	100				
3.4.2	Develop a framework between the North East and NSM LHINs to describe how the LHINs will work with health service providers in Muskoka and Parry Sound on matters related to planning, funding, accountability, and communication.	In Progress	80	In Progress	20		
3.4.3	Perform outcome-based evaluation on one targeted mental health and addiction program. Once completed, determine the viability of utilizing the model with other programs.	Not yet Started	100				
3.4.4	Validate performance indicators for agencies delivering Assisted Living Services for High Risk Seniors (ALS-HRS) and monitor quarterly performance.	Not yet Started	100				
3.4.5	Develop a framework for performance monitoring and evaluation of Specialized Geriatric Services Program, including behaviours.	In Progress	100				

⁹⁴ Office of the Minister, Ministry of Health and Long-Term Care. *Patients first: action plan for health care*. Ministry of Health and Long-Term Care; 2015.

⁹⁵ Ministry of Health and Long-Term Care. *Open minds, healthy minds. Ontario's comprehensive mental health and addictions strategy*. Ministry of Health and Long-Term Care; 2011.

Action Plans and Interventions		2016/17		2017/18		2018/19	
		Status	%	Status	%	Status	%
3.4.6	Finalize the Assess & Restore Performance Monitoring and Evaluation Framework and monitor quarterly performance.	In Progress	100				
3.4.7	Monitor the quarterly activity statistics for Adult and Pediatric Diabetes Education Programs as a means of informing regional and sub-regional planning.	In Progress	100				
3.4.8	Evaluate the current implementation of nsmCHIP Business Intelligence Initiative as per project plan in terms of the achievement of deliverables, risks, issues, privacy impact, and cost/benefit.	In Progress	100				
3.4.9	Evaluate the current implementation of Telehomecare. Identify if the program is improving health outcomes, connecting across service providers, and delivering value for money.	In Progress	100				
3.4.10	Develop scorecards which enable the LHIN as funding stewards to be effective in accurately monitoring funding as it relates to outcome achievement. Scorecards to be developed for the community sector and acute care.	In Progress	100				
3.4.11	Configure existing software solutions to streamline internal processes and allow LHIN staff to more effectively and efficiently manage projects and monitor performance.	In Progress	100				

Measuring Success

- Increase number of amended funding agreements inclusive of regularly reported performance indicators for mental health and addiction Phase 1 and Phase 2 strategic funding
- Increase number of high risk seniors receiving ALS-HRS services
- Decrease number of Emergency Department visits by ALS-HRS clients, reported by CTAS
- Decrease number of hospital admissions for ALS-HRS clients
- Increase number of ALS-HRS clients put on service from hospital with ALC designation
- Increase number of incremental attendances / visits for Assess & Restore clients
- Increase number of unique individuals served by Assess & Restore
- Increase number of clinicians trained through Geriatrics Training
- Decrease percentage of unplanned, less urgent ED visits within the first 30 days of discharge from hospital for Assess & Restore clients
- Decrease unplanned readmission to hospital within 30 days of discharge from hospital for Assess & Restore clients
- Increase number of clients served by Adult Diabetes Education Programs
- Increase number of clients served by Pediatric Diabetes Education Programs
- Increase number of clinical interactions for Adult Diabetes Education Programs
- Increase number of clinical interactions for Pediatric Diabetes Education Programs
- Increase number of patients enrolled in Telehomecare per dollar allocated to the program.
- Increase percentage of HSPs reporting a balanced fund type 2 budget
- Decrease percentage of HSPs reporting portion of budget spent on admin is within upper corridor of MSAA
- Increase percentage of HSPs meeting or exceeding 75% of functional centre level indicators for targeted service activity
- Increase percentage of HSPs meeting or exceeding 75% of functional centre level indicators for the number of individuals served
- Decrease hospital admission and readmission rates for mental health by age group

- Decrease hospital admission and readmission rates for substance abuse by age group
- Decrease ALC to mental health and addiction services
- Decrease number of CTAS IV, V Emergency Department visits
- Decrease ALC to home with community services
- Decrease ALC to home with CCAC
- Decrease ALC to Convalescent Care Program (CCP)
- Decrease rate of Emergency visits for conditions best managed elsewhere (MLAA Indicator)
- Decrease ALC Rate (MLAA Indicator)
- Decrease repeat unscheduled ED visits within 30 days for Mental Health conditions (MLAA Indicator)
- Decrease repeat unscheduled ED visits within 30 days for substance abuse conditions (MLAA Indicator)

Risks and Mitigation Strategies

Risks	Mitigation Strategy
▪ Service or indicator data may be limited, untimely, or not valid. Outcome related data can also be subjective, difficult to quantify, and hard to collect. These risks could impact the quality of a current state inventory or indicator selection/development.	Reduce likelihood by leveraging the expertise of the subject matter experts in data analysis and performance to identify appropriate data sources.
▪ Discussing and developing clear processes across LHINs for mental health and addiction will take time and this can create a risk or perception that the issue is being disregarded.	Mitigate risk through engagement and communication with the providers of mental health and addiction services in the Districts of Parry Sound and Muskoka. Ensure consistency in messaging from both the NSM and NE LHINs.

Key Enablers

NSM LHIN Clinical Planning Tables and Primary Care Network – The planning tables, councils, and project steering committees across the region all bring with them a range of clinical and subject matter expertise that is leveraged to inform the creation of appropriate indicators to measure system performance. The specific groups that will enable the evaluation work in the upcoming fiscal year will include the Mental Health and Addiction Project Team, Home and Community Capacity Project Team, and Community Support Services Collaborative among others.

Existing Telemedicine Assets – Significant investments have been made in recent years by the NSM LHIN to ensure that a broad range of providers have access to telemedicine equipment. These assets can now be leveraged to their maximum capacity to deliver care. The presence of existing systems serves as an enabler to improving access to care. The NSM LHIN has an extensive telemedicine network including access to telemedicine equipment in 22 out of 25 of the region's long-term care homes. There are also a number of staff resources dedicated to the provision of services via telemedicine across the region. The focus for the upcoming year will be to provide better access to care in a manner that leverages existing technological resources and maximizes efficiency.

Nurse Practitioners in Long-Term Care – The local nurse practitioner positions that have recently been added to local long-term care homes will directly impact primary care provision in the long-term care setting, and also can act as enablers and clinical experts for identifying current issues and opportunities related to telemedicine.

Conclusion

The North Simcoe Muskoka LHIN's Annual Business Plan (ABP) for 2016/17 presents the first year of operational planning to support delivery on the three strategic priorities articulated in the NSM LHIN's 2016-2019 Integrated Health Service Plan (IHSP). For each of the fourteen IHSP goals aligned with these strategic priorities, the Annual Business Plan identifies specific actions and associated indicators of success that will be measured to ensure LHIN accountability for results. The three strategic priorities established in NSM's IHSP are:

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

The 2016/17 ABP builds upon achievements to date and reflects existing and emerging provincial directions that help to shape and drive the work that takes place at the local level. In developing this plan, the LHIN leveraged content expertise to ensure alignment with provincial direction as well as incorporating local health system data and the input of regional stakeholders obtained through the IHSP process. Stakeholder consultations included NSM residents, health service providers, and Governors from each of the five communities and included representation from the region's diverse populations. Community and stakeholder engagement supports the development of a business plan that is reflective of both local needs and priorities and the provincial mandate.

The 2016/17 ABP will guide the NSM LHIN's operational work in the coming year, and represents the first of three successive Annual Business Plans that will move the NSM LHIN forward in delivering on the 2016/19 IHSP priorities and goals. Over the coming year, the NSM LHIN and its Board of Directors will work collaboratively with health service providers and system partners to continually improve and support the health outcomes of North Simcoe Muskoka's residents. In doing so, the NSM LHIN moves toward achieving the vision for the local system: **Healthy people. Excellent care. One system.**

Appendix A: Integrated Communications Strategy

Objectives

The business objectives of the North Simcoe Muskoka LHIN's 2016/17 Annual Business Plan support the LHIN's vision, mission, and values, as well as the strategic directions of the NSM LHIN's IHSP 2016-2019, and the achievement of the health system transformation agenda as it is implemented across the LHIN.

The Communication strategy will support NSM LHIN's 2016/17 business objectives through:

- Education and awareness of system-wide change initiatives and strategic priorities outlined in the IHSP
- Activities that align with provincial priorities
- Tracking and evaluating communication activities outlined in this strategy

The strategy will continue to:

- Foster an understanding of the need for health system transformation both internally and externally
- Build support for the 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
- Align health service providers to the strategic directions outlined in IHSP 2016-2019, with a focus of helping NSM residents spend more time in their homes and their communities
- Inform organizations and individuals on how they can participate in the success of health system transformation
- Mitigate communication risks of negative publicity by proactive media monitoring and evaluation
- Provide information on performance and progress on the implementation – document successes and share it
- Guide the communications activities of the NSM LHIN (Board and staff) and health system partners involved in initiatives contained in ABP 2016/17

This strategic focus will inform LHIN communications activities that will continue to build awareness and reinforce the purpose/goals/objectives of both the LHIN organization, and the LHIN in working collaboratively to achieve health system transformation.

It also means working in partnership with the Ministry of Health and Long-Term Care and the other 13 LHINs to build awareness and participation on a coordinated provincial level that will support understanding across shared audiences.

Communications Objectives

1. Build confidence among North Simcoe Muskoka residents that:
 - progress is being made to improve access to health services
 - progress is being made to improve the patient experience
 - the system is sustainable, being effectively managed, providing value for tax dollars
 - the system is transparent
2. Increase health literacy to enable and support Ontarians to live healthy lives, and manage their illnesses better.
3. Engage providers, stakeholders, and system leaders to become active participants in and ambassadors for transformation.

Context

LHINs are being recognized as local system managers that play a central leadership role in driving health system transformation. IHSP 2016-19 and the initiatives laid out in ABP 2016/17 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.

Patients First: Action Plan for Health Care, announced by the Ministry of Health and Long-Term Care in February 2015, focuses the work of the ministry and the Local Health Integration Networks on the needs of residents, ensuring they have:

- Faster access to the right care
- Better home and community care
- Information to make the right decisions about their health
- A sustainable universal health care system for generations to come

A 'patients first' health care system is one designed by people requiring care in partnership with health service providers and other community supports, which leads to integrated services and better outcomes.

The NSM LHIN's Integrated Health Service Plan 2016-2019, aligns with the ministry's four themes of Access, Connect, Inform, and Protect. Putting the patient first, NSM's three strategic objectives will:

- Improve access to appropriate care – improve access to the best possible care in the most appropriate setting to optimize health outcomes.
- Build capacity and enhance coordination – enable patients to receive high quality, coordinated care across the care continuum while successfully navigating a complex health care system.
- Drive system sustainability - promote system sustainability, including accountability for results, return on investment, access to services, and appropriate use of system resources.

By putting patients first, the NSM LHIN and its health system partners will:

- Support residents to make healthier choices and help prevent disease and illness.
- Engage residents on health care, so we fully understand their needs and concerns.
- Ensure communications focus on people, not just their illness.
- Help NSM residents understand how the system works, so they can find the care they need when and where they need it.
- Be more transparent in health care, so residents can make informed choices.

Audiences

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

Primary

- **Health Service Providers** across NSM and surrounding LHINs including: Health Service Provider Boards, Leadership, Front Line staff (including union leadership) and Primary Care Providers
- Patients / Caregivers / Families
- **Public:** Diverse populations (Anglophone, Francophone, First Nation, Métis, Inuit)

Secondary

- **Health Care Associations:** OHA, OACCAC, OANHSS, OLTCA, OCSA, etc.
- **Government:** Municipal, Regional, Provincial, Federal
- Service Organizations
- Media
- Other LHINs across the province

Strategic Approach

This strategy will guide the communication activities of the NSM LHIN (Board and staff) and health service provider partners involved in initiatives contained in the ABP 2016/17. It is overarching and will be supported by supplemental communications plans related to specific initiatives undertaken to support areas of focus detailed in the ABP:

- Seniors care
- Technological integration
- Primary care and Health Links
- Home and community care
- Long-term care redevelopment
- Palliative care
- Home and Community Capacity services

These plans will outline the context for each area of focus, as well as timelines, audiences, tools/tactics, specific key messages, and deliverables. The areas of focus within the communication plans' objectives will be to ensure clarity of vision and messaging, build momentum and confidence; recognize and respect stakeholders and their interests, and establish and nurture a partnership approach to achieving desired system improvement outcomes.

Key Messages

Provincial

“Patients First” means a caring, integrated experience for patients and faster access to quality health services for all Ontarians.

The Patients First: Action Plan for Health Care sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre of the health care system by improving the health care experience:

- **Access:** Improve access - providing faster access to the right care
- **Connect:** Connect services - delivering better coordinated and integrated care in the community closer to home; providing better home and community care
- **Inform:** Support people and patients - providing the education, information and transparency Ontarians need to make the right decisions about their health
- **Protect:** Protect our universal public health care system - making decisions based on value and quality, to sustain the system for generations to come

As the next logical step in the *Patients First: Action Plan for Health Care*, the *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* proposes a path toward providing better access to care no matter where you live by better connecting health care services.

North Simcoe Muskoka

The NSM LHIN collaborates with health service providers and community partners, enabling them to play an active role in transforming the health system to provide best practice, quality care that meets the needs of residents today and into the future.

The NSM health system needs to be adaptable to the changing environment and fiscal realities.

NSM residents continue to be engaged and play an integral role in the development of the health care system. Changes to the health care system will ensure providers come together in a coordinated manner that will enable the delivery of better, safer patient outcomes.

The NSM LHIN and its health system 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 health service providers, funded and non-funded, to provide care in the most appropriate setting. What does this mean for residents? It means getting the care they need, when they need it, in the most appropriate place, and by the most appropriate provider.

Chronic Conditions

- Populations are growing and aging, and the rates of chronic conditions are rising – North Simcoe Muskoka is no exception.
- NSM LHIN is 2nd worst in the province to have residents dealing with a chronic condition or multiple chronic conditions - and the numbers are increasing.
- NSM LHIN is the highest in the province to have residents with arthritis, asthma, cancer, heart disease, and high blood pressure – and the numbers are increasing.
- NSM LHIN will be developing and implementing a Patient Self-Management Program to assist individuals in optimizing their chronic disease management.

Primary Care

- While NSM is the third best LHIN in the province with 96.5% of residents attached to a primary care provider – we are the third worst when it comes to residents accessing after hours care without going to an emergency department – after 5 pm, weekends, and holidays.
- 7 out of 10 NSM residents, when they are sick or need to be seen by their physician, have no access to either same day or next day appointments.
- The NSM LHIN will be working in partnership with primary care providers, to ensure residents have access to their provider when they are sick reducing the possible need for an ED visit.

Mental Health and Addiction

- NSM residents wait longer for mental health services – abuse services 60 days vs the provincial median of 3 days; community withdrawal management 7 days vs the 1 day provincial median; and, community treatment for problem gambling 10 days vs the 5 days provincial median.
- NSM LHIN will be developing a more efficient referral and placement process to assist individuals in accessing mental health and addiction services.

Alternate Level of Care (ALC)

- In North Simcoe Muskoka, as in most of the province, we continue to have an Alternate Level of Care or ALC issue.
- ALC patients who remain in hospital awaiting home and community services are at increased risk of deteriorating.
- The NSM LHIN will be working to increase capacity, integration and coordination across the health system to provide care options for patients that remain in hospital designated ALC.

Seniors

- 19% of NSM residents are aged 65 and older - an increase of 3% from the 2006 census.
- The projection for 2015 will be that NSM LHIN will have the 3rd largest seniors population in the province.
- The NSM LHIN is moving forward with the implementation of a Regional Seniors Health Program.
- Specialized Geriatric Services will be the first seniors service implemented under the regional program, with a focus on behaviours.

Palliative Care

- The NSM LHIN will be working with the NSM Hospice Palliative Care Network to develop an NSM integrated regional palliative care strategy in alignment with direction from the Ontario PC Network.

Long-Term Care

- NSM LHIN has 26 long-term care homes, 12 of which require re-development over the next 10 years to meet provincial long-term care standards.

Health Links / Technology

- The NSM LHIN will be supporting the roll-out of the electronic coordinated care tool for all five of the region's Community Health Links.
- The tool enables patients and providers to be connected electronically with all the different providers in the circle of care.

Tactics

As described above, detailed tactics will be an integral part of each area of focus' communications plan. Some high level tactics that may be undertaken include:

- News releases
- Blast emails
- Community reports
- 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

Evaluation

Identifying and tracking critical communications success factors will enable the NSM LHIN to more effectively identify whether communication activities have been successful and develop additional strategies as may be appropriate.

Critical success factors may include:

- Health service providers across the NSM LHIN are engaged early and frequently, and can see how their participation is impacting implementation.
- For all communication / community engagement events held by the LHIN, opportunities for questions/answers will be provided to attendees to understand their literacy relative to LHIN activities/programs/initiatives.
- In addition, online surveys will be utilized, in conjunction with face to face feedback opportunities, to establish a literacy baseline which will inform the focus for communications in future years
- Track the number of positive print or broadcast media articles/coverage focused on improved access to health services and an improved patient experience.
- Using social media metrics, measure audience reach and engagement through NSM LHIN social media applications.

Through feedback mechanisms and ongoing assessment, the LHIN will monitor the effectiveness of communications vehicles and messages and will recalibrate and adapt plans as needed to support the achievement of the Annual Business Plan's areas of focus. Performance measures to support the success factors listed above may include:

- The consistent use of relevant and applicable messaging in materials prepared by LHIN staff and the Councils that support health system transformation work being done through *Care Connections* (10-year Integrated Health Service Plan)
- The number of inquiries by stakeholders and the public regarding clarification of direction, progress being made, and expected impacts on local health services
- Level of engagement by stakeholders, health service providers, persons with lived experience, and the public in response to LHIN community and stakeholder engagement efforts/activities/events
- Comments received through the NSM public website
- Comments received through engagement activity (feedback forms, interactive discussions)

NSM LHIN Communications Planning Process



Appendix B: Community Engagement Strategy

Health care planning in North Simcoe Muskoka is centred on the needs and experiences of people as patients, clients, residents, family members, caregivers, and key stakeholders. Community engagement continues to be a high priority as it relates to the planning and provision of high-quality, patient-centred care. Not only is community engagement a foundational element of the *Local Health System Integration Act*, but patient-centred care is also identified also as a key element of the *Patients First: Action Plan for Health Care*.

There are a number of activities that occur on an ongoing basis in the North Simcoe Muskoka LHIN to ensure that health system planning is informed by residents, patients, health service providers, front line staff, and a broad range of community stakeholders. Some activities are specific to collaborative health system planning for a certain sector or clinical area. This planning is always informed by patient outcomes and feedback. Other community engagement activities are designed to be focused on soliciting more general feedback. In these instances, the information gained and gaps addressed by those participating are brought back to the relevant planning groups and programs for inclusion in their work. Notice of planned consultations, as well as any project or consultation-related reading materials are continuously posted on the NSM LHIN website.

It is part of the LHIN's role to ensure planning is responsive to the needs of the community, residents, patients, health service providers, and other stakeholders. The planning tables, councils, and project steering committees across the region all bring with them a range of clinical and subject matter expertise that is leveraged to inform the creation of appropriate indicators, with which to measure system performance. Many of the LHIN planning tables have residents, patients, and/or caregivers who provide the voice of lived experience and represent a range of different demographic or geographic areas. These participants are encouraged to share their stories and provide context to how the work of the committee has real potential implications for the members of the community. The NSM LHIN continually looks to increase participation and seek new ways of incorporating the patient voice into LHIN planning activities.

As noted, a range of stakeholders have been identified as valued sources for input. Community engagement aims to ensure their feedback is captured and used as effectively as possible in creating positive change in the health care system. The goals of community engagement in North Simcoe Muskoka are:

- To solidify the key role that patients, residents, health service providers, and other stakeholders play in identifying community needs, gaps, and successes and informing change across the local health care system;
- To be highly inclusive and equitable with a range of opportunities available for patients and stakeholders to provide their perspective;
- To identify gaps, needs, and successes that become a key form of evidence to drive planning and system improvement;
- To ensure stakeholders feel valued as contributors and see how their feedback and participation is impacting the design, quality, and sustainability of the health care system.

As the health care system moves forward and continues to evolve, there will be further opportunities for engaging stakeholders from the NSM community and beyond. Throughout the 2016/17 Annual Business Plan, community engagement activities, committees, and initiatives have been identified as key enablers of the work. As new areas of work are identified in 2016/17, the NSM LHIN will continue to engage stakeholders in supporting home and community care, primary care transformation, and stronger collaboration with public health. The patient voice, the engagement of the community, and perspective of health system partners will all be essential to success in these areas.

Cross-Sector Community Engagement

There are a number of community engagement events or initiatives that are ongoing in the NSM LHIN and do not represent one particular topic, sector, or clinical area. The following are a sampling of these broader community engagement initiatives, with additional engagements added as required for specific purposes.

NSM LHIN Regional Governance Sessions – Each spring and fall, Governors who sit as members on the Boards of Directors for health care and other partner organizations gather in each of North Simcoe Muskoka's five communities. Regional Governance sessions provide ongoing opportunities to network and partner, and for sharing of best practices and knowledge at both the local and system level.

NSM LHIN Governance Education Summit – This annual summit is organized for Governors who sit as members on the Boards of Directors for health care and partner organizations across the region. It provides a primer on governance, and touches on intermediate and advanced governance issues. Discussion time is provided so attendees can share best practices and knowledge with colleagues from across the region and make important partnership connections. The content of the Governance Education Summit is designed to be responsive to the current needs and priorities of attendees. Topics currently include:

- The roles and duties of boards,
- The unique challenge of public sector governance,
- Shifting to system thinking,
- Board Basics – what you need to have in place,
- Leading practices in governance, and
- Emerging trends in public sector governance including system, collaborative, and generative governance.

NSM LHIN Patient Caregiver Family Advisory Panel – The Patient Caregiver Family (PCF) Advisory Panel plays a crucial role in ensuring initiatives maintain a patient-centred focus and that the patient voice is heard and included in all levels of the planning, implementation and evaluation. Members of the panel share their stories of health care in the region and their vast experience to support the identification of gaps and needs from the perspective of patients, family members and unpaid caregivers. The panel also acts as a valuable resource for LHIN staff to work through current and future initiatives to ensure a patient-centred focus. Members also provide feedback on the development of LHIN strategic priorities, and the inclusion of the patient and caregiver voice in LHIN communications.

NSM LHIN CEO Monthly Meetings with Patients, Caregivers, and Family Members – In addition to being members of the NSM LHIN PCF Advisory Panel, the NSM LHIN CEO and Community Engagement Coordinator meet informally with people interested in sharing their stories, experiences, and ideas regarding the health care system within North Simcoe Muskoka. Meetings occur at least once a month to ensure that the patient voice is heard directly by key LHIN decision makers, and stories are shared with councils, committees, and working groups to inform their ongoing work. Often, people the CEO meets with, are invited to become directly involved with a council, committee, or working group specific to the experiences of that individual patient or caregiver.

NSM Care Connections Forum – The annual Care Connections Forum is a large LHIN-wide event, in which approximately 300 key stakeholders gather to strengthen relationships, share best practices, and transfer knowledge. Break-out sessions are developed in consultation with LHIN planning tables to ensure inclusion of the most relevant information. All break-out sessions aim to be interactive, with members of the Patient Caregiver Family Advisory Panel and community included. The 2016 Forum will take place in May, and key topics will include home and community care, health system funding, the sustainability of Health Links, patient safety and quality, and the patient and caregiver experience.

Community Surveys – Community surveys are utilized frequently to solicit feedback from health community members and service providers. Recent examples of community surveys include those which sought feedback to inform the development of the NSM LHIN Integrated Health Service Plan, primary care planning, and gather feedback on the *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario, Discussion Paper*.⁹⁶ Surveys are provided in both French and English, and often include questions about the demographics of the participants, including self-identification to ensure the responses gained are reflective of a representative sample.

Health System Funding Reform (HSFR) Local Partnership Group – The province has mandated the creation of a HSFR Local Partnership to assist with capacity planning and change management around Health System Funding Reform. The NSM LHIN's HSFR Local Partnership includes representation from hospitals, the CCAC, and long-term care, and has been working collaboratively since January 2013 to implement Quality Based Procedures at the local level. The group informs the distribution of resources, shares best practices, and identifies models of care including care paths, policies and procedures to implement at an organizational level in order to meet provincial standards. The local partnership uses the results of the Quality Based Procedures Implementation Index to inform their work.

Regional Quality Table – Over the past year, the NSM LHIN has partnered with Health Quality Ontario to work towards establishing a Regional Quality Table. This group will provide a forum to discuss quality improvement strategies across the LHIN and align these strategies with regional and provincial strategic directions. It will be led by a regional clinical chair and will be comprised of regional clinical leads, sector leaders, and a Health Quality Ontario regional quality improvement specialist. This table will be a valuable resource for the NSM LHIN, as it will provide a venue to discuss performance improvement, align efforts across sectors, develop standardized methods of care, and share best practices throughout the region.

Service Accountability Agreement Information Sessions – There are three Service Accountability Agreement Information Sessions that take place each year across the LHIN; one for each sector including hospital, community, and long-term care. They are conducted via webinar/teleconference and are attended predominantly by administrators, executive directors, and senior finance personnel. These sessions are a means of providing information and seeking feedback from health service providers on the inclusion of indicators, completion of schedules, and sign-backs for service accountability agreements.

Simcoe County Local Immigration Partnership (SCLIP) – Beginning in 2016/17, the LHIN French Language Services Coordinator, Aboriginal Health Liaison, and Equity Lead will be participating on the SCLIP with a lens on health equity. This partnership is led by the County of Simcoe and focused on the development of settlement strategies for newcomers to the region. As such, the LHIN Liaison will be building relationships, bringing opportunities forward with regards to building and improving health equity, and gathering feedback on behalf of the LHIN from this group.

First Nations, Métis, and Inuit (FNMI)

The LHIN funds a variety of services through six organizations, specifically serving individuals who identify as First Nations, Métis, or Inuit, and also have many stakeholder partnerships across ministries and organizations that are not LHIN funded. Those who identify as FNMI call attention to challenges they face in receiving equitable access to health services including funding issues, lack of sensitivity to their culture, and a lack of targeted programs that focus on their particular health needs. Engagement of the FNMI community helps to ensure that LHIN work continues to be informed by their needs and perspectives, and that traditional practices and the unique cultural needs of this population are honoured and incorporated. The NSM LHIN makes concerted efforts to have individuals who identify as FNMI participate on all LHIN planning and engagement groups. Over the course of 2016/17 the number of groups

⁹⁶ Ministry of Health and Long-Term Care. *Patients first: a proposal to strengthen patient-centred health care in Ontario*. MOHLTC; 2015.

with FNMI representatives will be increased. The NSM LHIN and LHIN Aboriginal Liaison will participate in the following engagements during 2016/17.

Aboriginal Health Circle Meetings – These meetings are led by FNMI service providers in the community. They are attended by the LHIN, and are a valuable opportunity for the LHIN to learn more about the needs of the community, and communicate opportunities for FNMI participation in regional initiatives.

Aboriginal Health Forum – The two-day Aboriginal Health Forum, held each spring, explores health issues across the life cycle, through a format of interactive workshops, key-note speakers, and community discussion. Participants gain a better understanding of the holistic perspective of health, wellness, and Mino'Bimaadziwin (meaning “The Good Life”). The forum is attended by health care partners, the LHIN, and members of the community. It has strong attendance and increases the visibility of the FNMI community in health care.

Meetings with First Nation Band Councils – In partnership with the Aboriginal Health Circle, LHIN leadership and the LHIN Aboriginal Liaison have annual meetings with the leadership of the four First Nation’s communities in North Simcoe Muskoka. These include the Beausoleil, Chippewas of Rama, Wahta Mohawk, and Moose Deer Point First Nations.

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

French Language Services (FLS)

There are currently eight health service providers that are identified and one that is designated to provide health care services in French throughout North Simcoe Muskoka. Community engagement efforts will be increased over the coming fiscal year to enable the completion of LHIN deliverables in a manner that is responsive to the needs of the community. A continued partnership with the French Language Health Planning Entity (Entité 4) is key in advancing the LHIN priority of meeting the needs of the Francophone community. The primary role of Entité 4 is to support the engagement of the Francophone population by soliciting feedback regarding health needs and priorities, health services available, and the potential identification of organizations for French language services. Feedback from the community can then be used as the foundation for informed, evidence-based, and patient-centred planning.

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

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

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

Acute Care

Stroke Steering Committee – The Stroke Steering Committee is an ongoing table at which the LHIN engages hospitals, physicians, EMS, specialists, CCAC, and communities across the region for the purposes of collaborative planning. The Stroke Steering Committee continues to have extensive engagement with physician groups as a means of informing the work to be completed in this clinical area.

Critical Care Steering Committee – The Critical Care Steering Committee meets regularly and is represented by the hospitals within NSM. Their role is to collaborate and support the implementation of the *Ontario Critical Care Plan 2015-2018*, with the key goal to provide standard and consistent critical care across the region.⁹⁷

Emergency Department (ED) Steering Committee – The ED Steering Committee is a collaborative gathering of administrative and clinical leaders in emergency medicine. The committee enables sharing across health care providers of successful initiatives to improve emergency department flow and quality. As reforms in primary, home, and community care proceed, the emergency departments across the LHIN will be involved in planning proactively rather than simply responding to the impacts of the collective system.

Community-Based Care

Community Support Services (CSS) Collaborative – The CSS Collaborative is comprised of leaders from across the community sector and is a key partnership for the LHIN to work through issues and create opportunities. The Collaborative also provides a forum for soliciting essential feedback on gaps and concerns. A key example for 2016/17 will be the collaborative development of a central intake model in alignment with the implementation of the Personal Support Service (PSS) guidelines. In order to complete the work, stakeholders will need to come together to better understand the capacity of the system for central intake, and the readiness of organizations to potentially implement an electronic solution.

Palliative Care Planning Sessions and the NSM Hospice Palliative Care Network – Within the region, there is an existing NSM Hospice Palliative Care Network that includes regional stakeholders and providers. Relationships within this sector will act as the foundation for the creation of the provincially mandated NSM Regional Palliative Care Network. Over the coming year, Palliative Care Planning Sessions will be held as a means of further engaging a broader range of stakeholders and residents across the spectrum to create a vision and plan for an NSM palliative care program that considers comprehensive perspectives and needs. These sessions will be widely broadcast to regional providers via email invitations and websites.

Assisted Living Services for High Risk Seniors (ALS-HRS) Steering Committee – The ALS-HRS Steering Committee is comprised of LHIN representatives and community partners delivering ALS-HRS services. The group will continue to support LHIN efforts to work through the implementation of ALS-HRS services throughout the region. Strong relationships with the Home and Community Capacity Project Team and Community Support Services (CSS) Collaborative will continue to support effective communication and productive working relationships.

⁹⁷ Critical Care Services Ontario. Ontario critical care plan 2015-18. CCSO; 2015.

Seniors' Services

Seniors' Health Project Team – The Seniors' Health Project Team, as advisory to the LHIN and Specialized Geriatric Services Lead Agency, is accountable for regional system recommendations, ensuring that planning and implementation aligns with goals set out in relevant project charter(s). The team includes leaders from inside and outside the health system and partners with other planning groups such as the LHIN's Patient Caregiver Family Advisory Panel. The Seniors' Health Project Team will support planning and community engagement associated with the Specialized Geriatric Services that have resources dedicated for these purposes.

Long Term-Care Sector Summits – Two LHIN-led long-term care sector summits will be conducted in the spring and fall of 2016/17. These events will be held to ensure long-term care is adequately represented in the planning and execution of ongoing work across the region. It is an opportunity for the LHIN to continue to build and strengthen relationships with long-term care providers and their clients. Following these events, participants are encouraged to provide their feedback through an online survey. Historically, these summits have been well attended and the feedback has indicated that the commitment to a larger group event is of value for both the LHIN and the participating long-term care representatives.

Primary Care

LHIN Physician Lead, Clinical Planning and System Integration and NSM Primary Care Network – The NSM LHIN Physician Lead, Clinical Planning and System Integration will support LHIN work in enabling access to timely and appropriate primary care. The Lead will continue to strengthen relationships, act as a champion and subject matter expert, and play a key role in the leadership of the NSM LHIN and the NSM LHIN Primary Care Network. The Primary Care Network is a collaborative group of local physician champions who work to move the system forward, identify potential issues, and educate and engage their peers to bring their perspective and contribute to new initiatives.

Mental Health and Addiction

Mental Health and Addiction Project Team – The NSM LHIN benefits significantly from the inclusion of the Mental Health and Addiction Project Team within its decision making process and ongoing work. This group is made up of the key leaders within the NSM LHIN who provide mental health and addiction services to clients. The LHIN works in coordination with the Project Team to enhance access to mental health and addiction services for residents through the development, planning, implementation, and evaluation of new and existing programs, services and initiatives. The Project Team provides a consistent forum for discussion and collaboration where the LHIN can engage with health service providers, leveraging their collective clinical expertise and leadership.

Complex and Chronic Health Conditions

Health Links Community of Practice – The focus of the Health Links Community of Practice group is Health Link sustainability and standardization of practice and care. Areas of focus include reduction in the number of patients waiting for an alternate level of care (ALC), palliative care planning, data quality and consistency, quality improvement plans, and a regional and sub-regional focus on activities to reduce 30 day readmissions. The group consists of Health Link leaders, care coordinators, and front line staff as required to inform specific initiatives or act as subject matter experts in project work. The Health Links Community of Practice is very focused on the products of community and patient engagement in each Health Link, and utilizes patient satisfaction and patient stories in every community of practice meeting to drive the work at a regional level.

eHealth

NSM LHIN eHealth Advisory Committee – The committee is comprised of health service providers and leaders across multiple sectors. The purpose is to enable eHealth initiatives through the collective identification of gaps, needs, assets, and opportunities. Participants on the committee support the development and implementation of the LHIN eHealth Strategic Plan and act as subject matter experts regarding information technology, clinical workflow, and health administration. Members facilitate alignment between organizational and regional eHealth priorities, and champion the local implementation of projects initiated both regionally and provincially. The LHIN acts as a liaison to this group, and supports the facilitation of discussion and planning as needed in collaboration with the chairs. The LHIN shares the status of provincial and regional projects with the group, and brings back feedback from the committee to NSM LHIN, regional, and provincial tables.

Appendix C: LHIN Operations Spending Plan

LHIN Operations Sub-Category (\$)	2015/16 Actuals	2016/17 Allocation	2017/18 Planned Expenses	2018/19 Planned Expenses
Salaries and Wages	\$2,510,147	\$2,683,734	\$2,683,734	\$2,683,734
Employee Benefits				
HOOPP	247,138	263,005	263,005	263,005
Other Benefits	285,582	327,416	327,416	327,416
Total Employee Benefits	\$532,720	\$590,421	\$590,421	\$590,421
Transportation and Communication				
Staff Travel	\$28,857	\$28,000	\$28,000	\$28,000
Governance Travel	14,760	15,000	15,000	15,000
Communications	34,696	35,000	35,000	35,000
Other Recruitment & other	54,663	31,325	31,325	31,325
Total Transportation and Communication	\$132,976	\$109,325	\$109,325	\$109,325
Services				
Accommodation	\$225,000	\$178,000	\$178,000	\$178,000
Advertising		325	325	325
Banking	1,202	1,200	1,200	1,200
Community Engagement	34,709	35,000	35,000	35,000
Consulting Fees	195,209	70,000	70,000	70,000
Equipment Rentals	11,277	12,000	12,000	12,000
Governance Per Diems	96,500	97,000	97,000	97,000
LSSO Shared Costs	339,233	325,650	325,650	325,650
Other Meeting Expenses	38,086	40,000	40,000	40,000
Other Governance Costs	13,318	13,000	13,000	13,000
Printing & Translation	15,258	15,000	15,000	15,000
Staff Development	69,716	58,000	58,000	58,000
Total Services	\$1,039,508	\$845,175	\$845,175	\$845,175
Supplies and Equipment	18,677	18,000	18,000	18,000
IT Equipment	17,627	5,000	5,000	5,000
Office Supplies & Purchased Equipment				
Total Supplies and Equipment	\$36,304	\$23,000	\$23,000	\$23,000
LHIN Operations: Total Planned Expense				
Annual Funding Target	\$4,251,655	\$4,251,655	\$4,251,655	\$4,251,655
Variance				

Note: The budget does not include funding and costs for other initiatives.

Appendix D: LHIN Staffing Plan (Full-Time Equivalents)

Position Title	2015/16 Actual FTEs as of Mar. 31/16	2016/17 Forecast FTEs	2017/18 Forecast FTEs	2018/19 Forecast FTEs
CEO	1.0	1.0	1.0	1.0
Chief Operating Officer	1.0	1.0	1.0	1.0
Physician Lead	.50	.50	.50	.50
Directors	2.7	2.7	2.7	2.7
Senior Managers	1.5	2.0	2.0	2.0
Controller	.80	.80	.80	.80
Senior Advisors	2.2	3.0	3.0	3.0
Executive Co-ordinator	1.0	1.0	1.0	1.0
Executive Assistant	1.0	1.0	1.0	1.0
Co-ordinators	1.0	1.0	1.0	1.0
Performance Analyst	.90	1.0	1.0	1.0
Advisors	5.2	5.0	5.0	5.0
Office Co-ordinator	1.0	1.0	1.0	1.0
Communication - Lead	1.0	1.0	1.0	1.0
Communication Assistant	1.0	1.0	1.0	1.0
Administrative Assistant	2.9	3.0	3.0	3.0
Receptionist	1.0	1.0	1.0	1.0
Total FTEs	25.7	27.0	27.0	27.0

Note: The FTE's do not include staffing for other initiatives.