

2014/15

Annual Business Plan



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4.1 Context

4.1.1 Mandate and Strategic Directions

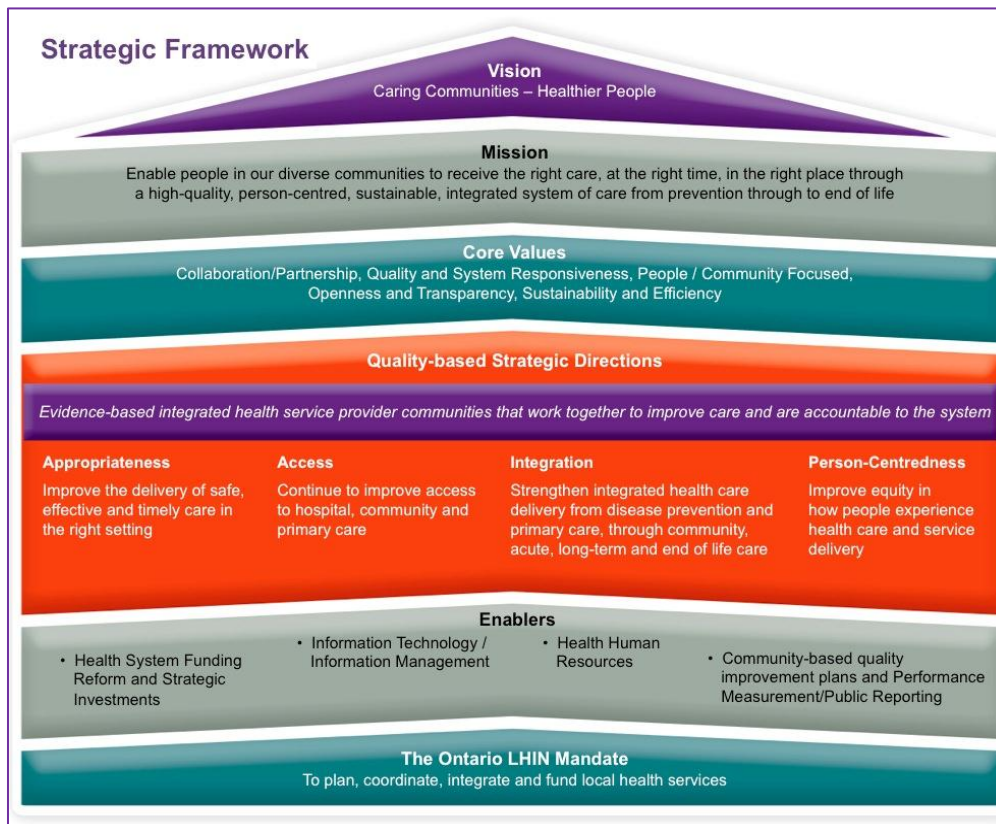
The Central Local Health Integration Network (LHIN) is one of 14 LHINs established by the provincial government through the *Local Health System Integration Act (LHSIA)*, 2006, to **plan, coordinate, integrate and fund health services at the local level**.

To achieve health system transformation, Central LHIN is guided by the provincial priorities outlined in *Ontario's 2012 Action Plan for Health Care* which targets three priority areas:

- Keeping Ontario Healthy
- Faster Access and a Stronger Link to Family Health Care
- Providing the Right Care, at the Right Time, in the Right Place

Central LHIN's Integrated Health Service Plan (IHSP) 2013-2016, is the roadmap to move us toward achieving our vision of *Caring Communities – Healthier People* by supporting a local health system that is there for our residents when they need it, now and in the future. Aligned with the provincial mandate, the IHSP 2013-2016 outlines four key quality-based strategic directions that are the focus of our activities and local investments over this three year period:

- **Appropriateness** - Improve the delivery of safe, effective and timely care in the right setting
- **Access** – Continue to improve access to hospital, community and primary care services
- **Integration** – Strengthen integrated health care delivery from disease prevention and primary care through community, acute, long-term and end of life care
- **Person-Centredness** – Improve equity in how people experience health care and service delivery.



The Central LHIN strategic directions are based on a quality framework meant to design a high-performing, sustainable health system grounded in evidence-based practice, enhanced collaboration across sectors, and improvements in the client healthcare experience.

The Central LHIN 2014-2015 Annual Business Plan (ABP) is a refresh of our roadmap to align results, new initiatives and capture priorities within the provincial and local context.

4.1.2 Overview of Central LHIN's Current and Future Programs and Activities

In 2013-2014, Central LHIN allocated approximately \$1.9 billion to Health Service Providers through 112 Service Accountability Agreements.

Table 1: Health Service Provider (HSP) type and number:

Provider Type	#
Hospitals - Public	7*
Hospitals - Private	2
Long-Term Care Homes	46
Community Care Access Centre	1
Mental Health and Addictions	21
Community Support Services	33
Community Health Centres	2
Total:	112

Source: MLPA as at October 2013 – * includes 6 hospitals and 1 service accountability agreement with a hospital outside the Central LHIN.

Advancing System Goals

As a guiding document, the 2013-2014 ABP enabled Central LHIN and its Health Service Providers to make advancements in IHSP 2013-2016 priorities, through the following improvements within the health system:

- **Appropriateness**
 - Alignment of Quality Improvement Plans (QIPs): Central LHIN “facilitated” alignment of hospital and community health centre Quality Improvement Plans to LHIN system level priorities so that initiatives across providers and the LHIN are aligned for maximum impact
 - Successful transition of Diabetes Education Program accountability to the LHIN for better alignment with local priorities
 - Implementation of Central LHIN's first Telehomecare program
 - Development of evidence-based care pathways (QBP) for Stroke, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease to be adopted by all Central LHIN hospitals

- **Access**

- Hospitals across Central LHIN committed to implementing a standardized best-practice approach to medical clearance in emergency departments for people with mental health and addictions conditions
- Embedded Rapid Response Nurses into two Health Links to provide quick transition support to meet needs of people with complex medical needs from hospital to home
- Implemented a new model of care for young adults with complex medical needs. The residential congregate care model provides improved access to community-based living so that these clients access the right care, at the right time, in the right place. ***This model is a provincial first and is being explored and considered by other LHINs***
- Recruitment of primary care physicians to Health Links is resulting in better access to primary care for patients with high needs
- Expanded professional and peer-led crisis services and case management services for mental health and addictions clients
- Implemented the Province's new Assisted Living Policy for High Risk Seniors resulting in the creation of 625 more assisted living spaces in our communities

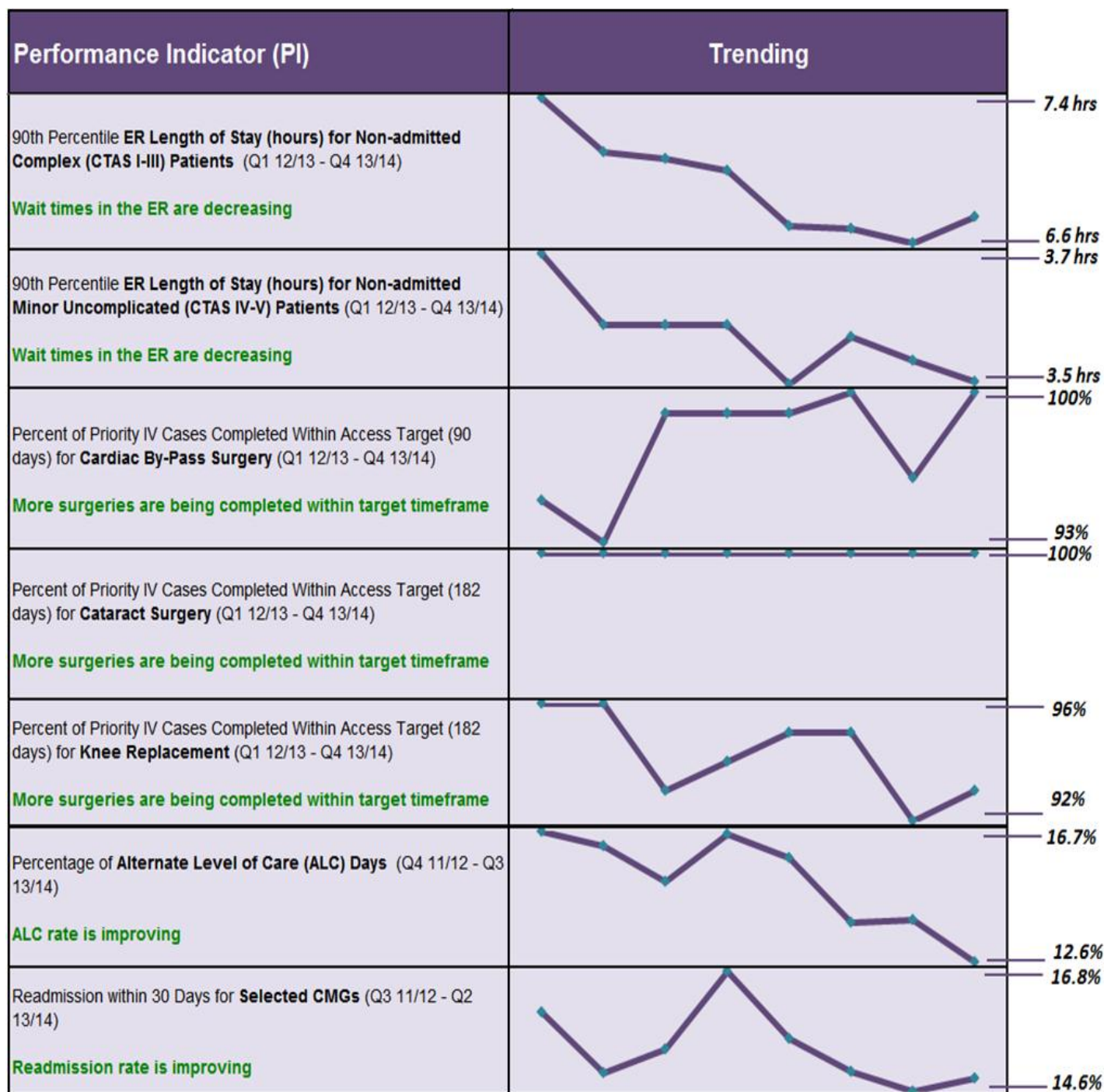
- **Integration**

- Implementation of two early adopter Health Links in Central LHIN with three additional Health Links in the planning stage
- Implementation of a single information resource of community services for providers and system users to improve knowledge of available services across the continuum (www.centralhealthline.ca)
- Piloted discharge planning process based on LACE (Length of stay, Acuity, Comorbidities, Emergency room utilization) tool at one hospital. To be spread across all Central LHIN hospitals in order to decrease Emergency room utilization and hospital admissions

- **Person-Centredness**

- Incorporated Public Health perspective into Health Links – Medical Officer of Health on Health Links System Planning committee
- Implemented provincial framework for physiotherapy and falls prevention classes across entire Central LHIN geography (urban and rural). This initiative is still underway
- Launched Central LHIN interpretation services program in community agencies
- Facilitated training on client self-management programs including **Wellness Recovery Action Plan** training for mental health and addictions clients and peer support workers

Central LHIN has continued to demonstrate progress toward meeting Ministry-LHIN Performance Agreement (MLPA) indicators for emergency room length of stay, surgical wait times and alternative level of care (ALC) days:



Source: Quarterly Stocktake Report May 2014

4.1.3 Environmental Scan of Opportunities and Risks

Who Lives in Central LHIN

Population		1.8M	Central LHIN's population represents 14% of the entire province – the largest number of Ontarians living in any LHIN
Population Growth		20.3%	Projected growth rate from 2011 to 2021
Immigration		48%	Almost half of our residents were not born in Canada (highest in Ontario)
Seniors	2012	12.5%	225,945 Central LHIN residents are aged 65+
	2021 (projected)	16.1%	Central LHIN will have highest number of seniors of all the LHINs in the province by 2021
Children (0-4 years)		5.6%	of our population are children aged 0-4 years – the highest proportion of any LHIN. Central LHIN also had the highest number of births (18,919) of all LHIN regions
Language		4.5%	of Central LHIN residents have no knowledge of English or French
Francophone		1.2%	of our population are Francophone
Aboriginal		0.4%	of our residents are Aboriginal, the majority of which live in urban centres

Source: IHSP Environmental Scan – MoHLTC Health Analytics Branch August 2012; Health Links Profile – MoHLTC Health Analytics Branch May 2013; BORN Ontario Perinatal Health Report August 2011.

Central LHIN is comprised of a unique urban/rural geography encompassing the northern section of Toronto, York Region and southern part of Simcoe County. Central LHIN has a growing population with increases in its population expected at a rate of 20.3% (2012-2021) making us one of the fastest growing LHINs in the province. With a rapidly growing population comes increased diversity and care needs for our residents.

New and emerging drivers impacting the health system within the Central LHIN include:

Seniors & complex patients with high use of health services and supports

The emergence of Health Links as a province-wide initiative has created a focus on streamlining and integrating care for our most complex patients. In addition, the impact of an aging population across Ontario has resulted in an increasing number of seniors who require more health services. Central LHIN residents and seniors with complex care needs require ongoing support and access to healthcare, often for extended periods of time. Acute care services such as emergency departments and hospital admissions are often utilized by our complex patients and seniors. To promote sustainability of a

coordinated, integrated and efficient health system, regular access to primary care, community health services and self-management support is imperative. New and emerging initiatives such as Health Links, the implementation of a regional hospice palliative care plan, expansion of community mental health and addiction services, and assisted living programs are underway to provide a system of collaborative care for our seniors and complex patients.

Patient Acuity

Central LHIN emergency departments see a large proportion of high acuity patients. In 2013-2014, Central LHIN ranked as the third highest LHIN in the province in terms of the number of emergency department visits that were higher acuity on the Canadian Triage Acuity Scale (CTAS) (*Source: Directory of Networks ER CTAS Hospital Level Comparison Report, 201403*). This is an indication of the ongoing increases in demand placed on Central LHIN health service providers.

Urban/rural mix and ability to access health care closer to home

Central LHIN encompasses a mix of rural and urban communities with 11% of residents living in rural or small population communities and 89% living in large urban centres. (*Source: Health Analytics Branch: Health Links demographic, census, and utilization profile: May 2013*). The ability to receive the right care, at the right time and in the right place closer to home is a priority for Central LHIN and is important to our residents. The development of a LHIN wide transportation model, expansion of the telehomecare and telemedicine programs, and physiotherapy reform are all evolving initiatives to support access to local health care services in communities across the LHIN.

Addressing health care needs of diverse communities

The Central LHIN is a diverse community with the highest proportion of immigrants in the province. Central LHIN is home to a small population of Aboriginal people, and approximately 1.2% of the population is Francophone. Health system planning for Central LHIN residents must promote holistic and culturally adaptive strategies for all, to better meet the care needs of diverse and at risk populations. By embedding these strategies into the development of Health Links and continuing to engage with our diverse communities, the needs of our residents will drive system change and guide new directions for health system planning.

High birth rate and proportion of children with medical complexity

Central LHIN has a high birth rate and the highest proportion of children aged 0-4 of all of the LHINs. Central LHIN also has the second highest number of children with medical complexity in the province (*Source: ICES, January 2012*). This will inform health system planning to address capacity needs for health services for all residents, both young and old.

4.2 Core Content – Template A

Integrated Health Services Priority

APPROPRIATENESS

Improve the delivery of safe, effective and timely care in the right setting.



IHSP Priority Description

Managing complex or chronic care needs through primary care with community supports can prevent or delay escalation to the point of hospital admission. In addition, people in hospital should be discharged when medically appropriate, to settings that provide care that is consistent with their needs.

Current Status

Scope of Services, Providers and Clients Served:

- Central LHIN funds 6 public acute care hospitals, 2 public hospitals, 46 long-term care homes, 54 community agencies, 2 community health centres and a community care access centre which support clients in the community and in their home
- A variety of programs are supported through our hospitals in caring for frail seniors and patients with complex conditions upon discharge from hospital. For example: Nurse Led, Geriatric and Mental Health Outreach Teams; 2 Health Link early adopters; Hospice Palliative Care Teams; and Rapid Response Nurses
- In 2012/13, 518,000 patients were seen in Central LHIN emergency departments, 115,000 patients were discharged from hospital, and hospital-based outpatient services provided almost 1.5 million patient visits. Central LHIN community agencies (including mental health and addictions and Community Health Centres) served over 80,000 individuals (*Source: MOHLTC HIT tool , Intellihealth Inpatient Discharge Table & DAD for hospital discharges*)
- Central Community Care Access Centre (CCAC) supports clients across the Central LHIN for community, home support and end of life care. In 2012-13, Central CCAC served 72,000 individuals (*Source: MOHLTC HIT tool*)
- Central LHIN works in partnership with 5 Central LHIN funded Diabetes Education Programs (DEPs) to coordinate, educate and promote self-management in care for people with or at risk of diabetes. Central LHIN DEPs are located in 2 Community Health Centres and 3 hospitals.

Approximately 16,000 clients a year receive care at a Central LHIN DEPs (Source: Central LHIN funded Diabetes Education Centre 2013-14 Q2 Statistical Reports)

- Clinical telemedicine consults are available to residents throughout the Central LHIN in hospitals, the community sector, long-term care homes and primary care. There were 6,512 Clinical telemedicine events in the Central LHIN from April 1 to September 30, 2013 (Source: Ontario Telemedicine Central Report, Volume 2, Issue 2, December 2013)
- Central LHIN implemented its first telehomecare program in 2013-14 servicing the South Simcoe Northern York Region Health Link. Telehomecare has emerged as a client-centered approach in the delivery of efficient and effective care to people with chronic disease such as chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF)
- In 2013-14, Central LHIN facilitated the implementation of Quality Based Procedures (QBPs) with the development and implementation of standardized evidence-based care pathways for Stroke, CHF and COPD across all Central LHIN hospitals

Key Issues:

- Increasing prevalence of seniors with complex medical conditions with high utilization of health care services and supports
- System navigation challenges for patients, caregivers and providers in where and how to receive timely care in the right setting once discharged from hospital
- Lack of capacity for seniors with conditions that are more highly represented in alternate level of care data (the frail elderly with behavioural conditions such as dementia)
- Lack of coordination and access to palliative care in the most appropriate setting. It has been estimated that few patients have access to palliative care and support appropriate to their needs (Source: Advancing High Quality, High Value Palliative Care in Ontario Declaration of Partnership, 2011)

Successes:

- Of the 15 MLPA indicators, Central LHIN has met or exceeded the provincial target in 11 indicators and ranks first among LHINs for 5 of the 15 indicators (Source: May 2014 MOHLTC Stocktake Report)
- Alternate Level of Care (ALC) performance has improved and Central LHIN % ALC days was below 13% for the first time in over 5 years (Source: quarterly MOHLTC Stocktake Reports)
- Central LHIN is ranked #2 in the province for having the lowest number of ER unscheduled visits/1000 population (Source: May 2014 MOHLTC Stocktake Report)
- Central LHIN met the 15% target for hospital readmission rate for selected conditions, and ranks #1 among all LHINs on performance for this metric (Source: May 2014 MOHLTC Stocktake Report)
- Central LHIN is ranked #1 among all LHINs on performance for three surgery wait time metrics: the percentage of priority 4 cases completed within the target timeframe for cancer, cardiac bypass, and cataract surgeries (Source: May 2014 MOHLTC Stocktake Report)
- As a result of physiotherapy reform, 2,500 new client assessments for one-to-one physiotherapy services and 1,600 assessments for group exercise and falls prevention classes were completed by CCAC as of September 2013 (Source: Central CCAC CHRIS Database September 2013)
- 14 long-term care homes in Central LHIN have telemedicine units to support resident medical consults and care needs, and additional units are being funded in 2013-14
- Central LHIN implemented its first telehomecare program in November 2013 and enrolled 27 patients during the first 2 months of the program

APPROPRIATENESS

Goals & Action Plans

Goal 1: Continue to advance more effective ways to deliver care that improves quality and is safer

Goal 2: Offer the most appropriate treatment settings

Goal 3: Use more evidenced-based decision making

Consistency with Government Priorities

Goals align with Ontario's focus on keeping people healthy and providing the right care, at the right time, in the right place. Supports Health System Funding Reform's (HSFR) focus on using evidence to drive strategic investments.

Action Plans/Interventions

Action Plans	Indicate the status of the project (Not yet started, in progress, deferred, or completed) and % completion anticipated in each of the next three years.		
	2014-15	2015-16	2016-17
Align hospital, CCAC and community health centre Quality Improvement Plans (QIPs) to LHIN priorities. Engage family health teams in alignment review	25% In progress	25% In progress	25% In progress
Continue to improve and plan for expansion of eReferral and/or resource matching across the health care continuum	25% In progress	25% In progress	25% In progress
Advance physiotherapy reform as a key component of the Senior's Strategy to prevent functional decline and reduce falls in seniors	50% In progress	25% In progress	25% Completed
Improve system capacity, coordination and care processes to reduce ALC pressures within Central LHIN hospitals	25% In progress	25% In progress	25% In progress
Implement evidence-based care pathways (Quality Based Procedures) as per MOHLTC schedule (e.g. pneumonia, hip fracture). This work will include the community portion of the pathways for 2013/14 QBPs such as Stroke, CHF and COPD	25% In progress	25% In progress	25% In progress
Expand telemedicine capacity LHIN-wide. This includes increasing clinical adoption, expanding telemedicine programs within long-term care, and expanding Central LHIN's telehomecare program	40% In progress	20% In progress	20% In progress

How we will measure success?

- All Hospital and Community Health Centre QIPs align with LHIN priorities. Family Health Teams engaged in QIP review
- Improved user satisfaction as measured by the Resource Matching & Referral user survey
- Plan completed for eReferral and resource and matching expansion across the health care continuum
- 16,295 seniors will have access to exercise and falls prevention classes (MLPA target)
- Achieve MLPA target for percentage ALC Days
- Quality Based Procedures (QBPs) implemented as per MOHLTC schedule
- Clinical telemedicine adoption increased by 10% yearly across Central LHIN
- Telehomecare expanded to include a minimum of 2 Health Links
- Achieve MLPA target for 30 Day Readmission Rate for selected CMGs (Case Mix Groups)

What are the risks/barriers to successful implementation?

- Willingness of Family Health Teams (FHTs) to align Quality Improvement Plans with LHIN priorities. FHTs do not fall under LHIN accountability.
- Multiple information systems are used by providers making improvements and planning for expansion for eReferral and/or resource matching more complicated.
- New exercise and falls prevention classes may require additional program locations, depending on evaluation of existing sites and programs
- Appropriate discharge destinations need to be available for clients with complex conditions and specialized care needs

Plan to mitigate risk?

- Engagement of FHTs through Association of Family Health Teams of Ontario (AFHTO) representatives and the Primary Care Council through the Primary Care Physician LHIN Lead
- Stage and appropriately scope planning work for expansion of eReferral and/or resource matching specific to particular sectors in the health care continuum
- Evaluate and monitor exercise and falls prevention program metrics and outcomes
- Continue to work with the Rehabilitative Care Alliance and community stakeholders to address capacity planning and enhance access to services in post-acute care settings
- Work with key stakeholders across the continuum of care to improve and standardize discharge processes, data integrity and support appropriate transition of long-stay alternate level of care patients into the community

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

- Continued collaboration and engagement with primary care providers, health service providers and other key stakeholders
- Clear vision and timelines for the rollout of eHealth initiatives
- Health System Funding Reform and strategic investments
- Timely implementation of the electronic Coordinated Care Tool through Health Links

- Aligning program initiatives focused on falls prevention and functional decline with key recommendations outlined in Dr. Sinha's 2013 Senior's Strategy Report
- Collaborating with the MOHLTC in the capacity planning process to support the long-term care needs of older adults

ACCESS

Continue to improve access to hospital, community and primary care services



IHSP Priority Description

The health system functions as a continuum. Every part is dependent on flow through, and access to, another part of the system. To maintain and improve how the system works, emergency departments, hospitals, post-acute services, primary care, long-term care, community care and palliative care service providers must work together to deliver access to the appropriate supports when needed.

Current Status

Scope of Services, Providers and Clients Served:

- Central LHIN has six public acute care hospitals, operating 8 emergency department sites and one urgent care centre
- Within Central LHIN hospitals, there are 176 inpatient adult mental health beds and 19 inpatient child/adolescent mental health beds (*Source: The Hospital Quarterly Report (SRI), Q2 2013-14*)
- Central LHIN has 11 family health teams (FHT), two Nurse Practitioner (NP) Led Clinics, over 1400 family physicians and over 1200 specialists (*Source: Central LHIN 2013 Community Report*). From February 2009 to August 2013, over 12,000 Central LHIN residents that needed a primary care practitioner were connected to a FHT or NP Clinic (*Source: Health Care Connect Monthly Data Report, August 2013*)
- Partnerships between our community agencies, central CCAC, hospitals and long-term care homes have supported new programs and services designed to assist clients in the community and reduce demand on acute care services. For example, the CCAC Rapid Response nursing program has provided post hospital discharge care to 980 clients from April to September 2013 (*Source: CCAC CHRIS Database*). Seven young adults with complex medical conditions have the opportunity to live in a home setting with support from the central CCAC and March of Dimes. In 2012-13, 325 seniors with complex medical needs received assisted living support with the implementation of a system- wide process for accessing assisted living/supportive housing (*Source: Central LHIN 2013 Community Report*)
- There are 23 community mental health and addictions agencies in Central LHIN specializing in case management, abuse, dual diagnosis, peer support, court support, eating disorders, supporting housing, vocational, concurrent disorders, opioid addiction and problem gambling.

The agencies served over 21,000 individuals in 2012-13 (Source: MOHLTC HIT tool)

- Currently there are 46 long-term care homes in the Central LHIN which provide beds for 7,244 residents. Access to LTC is often required for patients no longer requiring hospital care. In Q2 of 2013-14, 536 patients from hospital were transferred to LTC homes in Central LHIN (Source: Central CCAC Hospital Indicator Report November 2013)
- Central LHIN has funded hospitals to improve patient access and wait times for diagnostic and surgical procedures. In 2013-14, hospitals were able to perform additional procedures including: 14,000 MRI hours, 96 joint replacements, 1,931 CT hours, 402 general surgeries and 84 pediatric surgeries (Source: Central LHIN 2013-14 Wait Times Tracking)

Key Issues:

- Central LHIN emergency departments see a large proportion of high acuity patients. Central LHIN tied with one other LHIN as the 2nd highest LHIN in the province in terms of the percentage of ED visits that were higher acuity (CTAS 1, 2 or 3) (Source: Directory of Networks - ER CTAS Hospital Level Comparison Report, 2013-14)
- High cost users of the health system, including those with mental health conditions, have multiple chronic conditions and comorbidities and often access care through emergency departments
- The aging population has increased the need for timely access to home care, rehabilitation services, long-term care beds, primary care, and community supports. This includes the need for services to address the increasing number of people with cognitive impairment and challenging behaviours associated with mental health, addictions, dementia or other neurological conditions
- Limited access to services and supports for caregivers to reduce burnout and need for crisis support for ailing family members

Successes:

- Over the last six quarters, Central LHIN emergency room length of stay for all acuity levels has improved (see chart on page 4)
- Length of stay for non-admitted minor uncomplicated patients is ranked #1 in Ontario (Source: May 2014 MOHLTC Stocktake Report)
- Percentage of Alternative Level of Care (ALC) days for Q3 of 2013-14 was 12.62%, which is better than the LHIN target of 15% (Source: May 2014 MOHLTC Stocktake Report)
- The Behavioural Support Unit at Cummer Lodge, a service for seniors with cognitive impairment, is fully operational and has an occupancy rate of 92%
- In 2013-14, Central LHIN funded community programs to support community mental health and substance abuse case management and crisis services, trauma abuse services, streamlined access to supportive housing and additional assisted living programs for high risk seniors
- Many of Central LHIN's primary care, specialist and nurse practitioners have been active participants in the ongoing planning and implementation of Health Links

ACCESS

Goals & Action Plans

Goal 1: Continue to streamline the flow of people through hospitals to make the best use of resources

Goal 2: Improve access to primary care

Goal 3: Improve access for patients with life or limb threatening illnesses

Goal 4: Make it easier for people to move through the system to access the right care, at the right time, in the right place

Consistency with Government Priorities

Goals support the Ministry's priority of faster access and a stronger link to family health care. This includes reducing wait times and alternate level of care days, and improving access to services for seniors and mental health clients.

Action Plans/Interventions

Action Plans	Indicate the status of the project (Not yet started, in progress, deferred, or completed) and % completion anticipated in each of the next three years.		
	2014-15	2015-16	2016-17
Implement medical stability best practices in Central LHIN emergency departments for people with mental health and addiction (MH&A) conditions	25% In progress	75% Completed	
Increase use of electronic tools and other electronic methods to share information across providers including primary care. May include electronic hospital reports, coordinated care tools, or centralized repositories of clinical information for access by multiple providers	25% In progress	25% In progress	25% In progress
Implement the Provincial Life or Limb No Refusal Policy for referral, acceptance and repatriation of clients with a life or limb threatening condition within Central LHIN and GTA hospitals	100% Completed		
Expand access to community supports for people with complex care needs. Includes implementation of a system-wide process for placing clients in assisted living in support of Ontario's Senior's Strategy and may include supports to address caregiver burnout/respite care	50% In progress	50% Completed	
Expand access to services and supports for young adults with medical complexities that may also include developmental disabilities	25% In progress	25% In progress	25% In progress
Expand access to community mental health and addiction services with a focus on seniors and young adults	25% In progress	25% In progress	25% In progress

How we will measure success?

- Continued improvement in 90th percentile ER LOS for Admitted patients; achieve MLPA target (LHIN target: 30 hours)
- 80% of primary care practitioners with an Electronic Medical Record (EMR) implement Hospital Report Manager (HRM)
- 70% of primary care practitioners with an EMR implement Ontario Laboratory Information System (OLIS)
- Adoption of electronic coordinated care tool in a minimum of 2 Health Links
- Achieve the Life or Limb targets as set by the Critical Care Secretariat of Ontario and MOHLTC policy guide
- Reduce wait times for access to community mental health and addictions services

What are the risks/barriers to successful implementation?

- Multiple change initiatives are underway which may stretch the capacity of health service providers to expand access to community mental health and addiction services, programs for complex clients and supports for caregivers
- Timely deployment of eHealth initiatives is required to support increased adoption and coordination of the various provincial e-tools
- A standardized process to support the implementation of the repatriation component of the provincial Life or Limb Policy needs to be defined across GTA hospitals. The process needs to be aligned with CritiCall Ontario's Provincial Hospital Resource System Repatriation Tool. There are challenges related to limited bed capacity and on-call coverage for all specialties
- Development and implementation of the Life or Limb Policy is highly dependent on physician leadership and hospital buy-in. The implementation timeframe of the project will be a challenge
- Implementation of new assisted living policy requires successful transition of clients from existing providers to qualified CSS providers

Plan to mitigate risk?

- Clear and frequent communication with providers in order to prioritize initiatives. Includes supporting successful transition of high risk seniors as per Assisted Living Policy
- Continue to work closely with the eHealth provincial teams on strategic project phasing
- Facilitate collaboration among all Central LHIN hospitals and other key stakeholders (for example EMS, Criticall, other GTA LHINs) in implementing Life or Limb policy and developing standardized referral/acceptance/repatriation processes
- Utilize LHIN physician leadership to engage physicians and encourage buy-in

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

- Comprehensive and effective engagement with health service providers and stakeholders. Includes continued engagement of caregivers and clients to understand care needs, gaps and

future opportunities

- Timely deployment and sustained adoption of eHealth initiatives and tools
- Access to common wait lists to better understand service capacity and gaps
- Access to CCAC Client Health Related Information System (CHRIS)

INTEGRATION

Strengthen integrated health care delivery from disease prevention and primary care, through community, acute, long-term care and end of life care.



IHSP Priority Description

As our population ages and grows, the number of people living with complex medical issues and multiple conditions such as diabetes, congestive heart failure and chronic obstructive pulmonary disease, will go up. The demands on our community-based supports and services will also increase. As a result, there will be greater demand for services that address the entire spectrum of conditions a person experiences and that are integrated across the continuum of care.

Current Status

Scope of Services, Providers and Clients Served:

- Central LHIN funds six acute care hospitals, 46 long-term care homes, 54 community agencies, two community health centres and a community care access centre which support clients in the community and in their home
- Ten community agencies are funded by Central LHIN to provide community transportation services using paid drivers and volunteers
- Central LHIN has identified five Health Link regions, based on primary care referral patterns. Two early adopter Health Links are operational: South Simcoe Northern York Region Health Link and North York Central Health Link. Each Health Link is comprised of community, primary care, and hospital partners as well as patients, caregivers and other key stakeholders. As of Q3 of 2013-14, 69 patients with complex needs were enrolled in the two early adopter Health Links
- As part of Health Links, a single plan of care for those with complex needs is used that links across all providers involved in the patient's care
- Central LHIN funds a variety of providers to support end of life care. The Hospice Palliative Care (HPC) team based out of Southlake Regional Health Centre is a team of 7 nurses providing 24/7 palliative pain and symptom management services. In 2012-13 the HPC team received 1,147 referrals. Central CCAC provides palliative care support for clients across Central LHIN at home and in residential hospices. In 2012-13 the CCAC served 3,456 clients admitted to their oncology end of life program. There are 11 visiting hospices in

Central LHIN that provide visiting palliative care services through a network of approximately 900 volunteers. In 2012-13 these visiting hospices served 1,500 individuals. In addition, there are two residential hospices with seven palliative care beds, and a 10-bed residential hospice in York region has been approved by the Ministry with an expected implementation of Fall 2015 (Source: *Regional Hospice Palliative Care Program Capacity Building Plan (Draft)* – Central CCAC Sep 2013)

- Central LHIN is developing a comprehensive, integrated, regional program for hospice palliative care by collaborating with its Central Hospice Palliative Care Program Council and the Central CCAC to strengthen palliative care for patients in our communities, and to support more patients through the end of life period in their preferred locations
- Several electronic tools and methods are used to share information across providers. These include electronic medical records and hospital reports, e-Referral solutions and centralized repositories of clinical information for access by multiple providers

Key Issues:

- Timely communication and coordination between providers in hospital, community, long-term care and primary care continues to be a challenge especially for patients with complex medical needs
- Lack of IT infrastructure and integration. For example: there are currently 11 different Electronic Medical Records(EMR) that are used by primary care practitioners in the Central LHIN, making information sharing across providers more difficult. 29% of primary care physicians in Central LHIN do not use an EMR (Source: *Ontario MD*)

Successes:

- Two early adopter Health Links are operational and will also be early adopters of the electronic coordinated care tool
- Central CCAC launched the www.centralhealthline.ca website as single information resource of community services - to educate and increase awareness of the local health service options available
- Engagement of public health, emergency management services and primary care into Health Link planning to strengthen integration across sectors
- Increased adoption of Electronic Medical Records (EMR) within Central LHIN from 63% to 71% as of September 2013. EMR adoption will enable linkages between hospitals and primary care practitioners
- Development of a standardized discharge summary template to be used by all GTA hospitals upon discharge of the patient to their primary care provider
- Pilot of eLACE (**L**ength of stay, **A**cute admission, **C**omorbidities, **E**mergency visits) tool for discharge planning complete at one hospital. The tool helps to identify those at high risk of (re)-hospitalization

INTEGRATION

Goals & Action Plans

Goal 1: Create an integrated local system of care

Goal 2: Improve transitions of care across the health care continuum

Goal 3: Support patients with complex needs at high risk for hospital admission in gaining access to an integrated team of providers to address their needs

Consistency with Government Priorities:

Goals support several government initiatives including: better integration of the healthcare system across the continuum including family health care, acute care, long-term care and care in the community

Action Plans/Interventions

Action Plans	Please indicate the status of the project (Not yet started, in progress, deferred, or completed) and % completion anticipated in each of the next three years.		
	2014-15	2015-16	2016-17
Implement up to five health links in Central LHIN as systems of collaborative health care providers working together to improve delivery, integration and coordination of care. Two HLs underway, third for implementation in 2014-15 and additional two in 2015-16	75% In progress	25% Completed	
Develop a Central LHIN model to optimize LHIN funded community-based transportation services	75% In progress	25% Completed	
Investigate a strategy for centralized access and service integration in the Community Support Services Sector, including Acquired Brain Injury services and Attendant Outreach. Further the development of centralized access and service integration in the mental health and addictions sector	33% In progress	33% In progress	34% Completed
Reduce High Risk Utilization – Implement eLACE (Length of Stay, Acute admission, Comorbidities, Emergency Visits), tool for discharge planning that identifies those at high risk of hospitalization across all hospitals. Facilitate utilization of community tool via Health Links to identify those at risk for hospitalization and begin proactive service integration	25% In progress	75% Completed	
Implement Hospice Palliative Care plan to advance high quality and high value palliative care delivery in support of the declaration of partnership between LHINs, the Ministry and the Quality Hospice Palliative Care Coalition of Ontario	80% In progress	20% Completed	

How we will measure success?

- Implementation of third and fourth Health Links and complete planning for last one
- Increase capacity for community based transportation within allocated funding
- 2,063 high risk seniors will have access to Assisted Living supports as per MOHLTC Assisted Living policy
- Reduce 30 Day Readmission Rate for selected CMGs (Case Mix Groups). (Central LHIN 2013-14 MLPA target 15%)
- Total number of hospital days attributable to palliative care reduced by 10% by 2016/17

What are the risks/barriers to successful implementation

- Multiple change initiatives are underway which may impact the capacity of health service providers to implement
- Number and scope of providers involved makes communication, planning, implementation and sustainability efforts complex
- Timeliness and availability of technology infrastructure and integration to support communication across providers
- Acceptance of new models of care recommended as a result of the regional Hospice Palliative Care plan

Plan to mitigate risk?

- Clear and frequent communication with providers to prioritize initiatives
- Encourage health service providers to align with and leverage Health Links. Includes developing reasonable implementation plans for priority initiatives
- Work with the early adopter Health Links in setting them up to be successful adopters of the electronic coordinated care tool. Incorporate the implementation of electronic tools that are used to share information across providers into Central LHIN's Enabling Tools for eHealth 2014/15 plan
- Include a robust communication and engagement strategy in developing the regional Hospice Palliative Care plan

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

- Comprehensive and effective engagement with health service providers and stakeholders. Includes continued engagement of caregivers and clients to understand care needs, gaps and future opportunities
- Alignment of Hospice Palliative Care Plan with Health Links model
- Timely deployment and sustained adoption of eHealth initiatives and tools
- Health System Funding Reform and strategic investments

PERSON-CENTREDNESS

Improve equity in how people experience health care and service delivery



IHSP Priority Description

Central LHIN is committed to supporting a health system that puts people first and respects the individuality and diversity of its residents. Central LHIN will strive to reduce health disparities as a shared responsibility with its health service providers by integrating health equity into strategies and activities within its mandate and influence.

Current Status

Scope of Services, Providers and Clients Served:

- Approximately 7,000 Aboriginal people live in the Central LHIN. The majority of Aboriginal people in Central LHIN live off reserve, residing in North York, South Simcoe, Northern York Region and Central York Region. Programs to support Aboriginal communities include mental health and addiction services and diabetes education programs. Ongoing education and training is underway to support providing culturally sensitive services to the Aboriginal population living both on and off reserve (*Source: Statistics Canada's 2011 National Household Survey*)
- French Language Services (FLS) have been identified in three Central LHIN funded agencies including two hospitals and the Central CCAC. An additional two FLS designated agencies provide intake, case management, adult day program and primary care services within the Central LHIN region
- Peer led chronic disease self-management programs are available across the Central LHIN in rural, urban and aboriginal communities and in languages other than English. As of Q3 2013-14, 253 Central LHIN residents participated in Stanford Chronic Disease Self-management Programs (*Source: Self-management Advisory Committee Minutes, December 2013*)
- Central LHIN has one of the highest Health Care Connect (HCC) referral rates for the senior population 65 years and older (93.7%) and we improved matching of unattached patients through HCC by 10% (*Source: Central LHIN IHSP 2013-16*)
- In 2012-13 Central LHIN hospitals had over 14,000 visits to outpatient child and adolescent mental clinics and eating disorder clinics. Central LHIN community and mental health

agencies provided 108,000 case management visits and almost 200,000 visits for various mental health and addiction services (Source: MOHLTC HIT tool, 2012-13 data)

- Early adopter Health Links in South Simcoe Northern York Region and North York Central have patient/caregiver membership in order to embed the patient experience into Health Links planning

Key Issues:

- Central LHIN's planning areas are different; each has unique challenges and needs that must be considered when planning at a system level
- The need to provide culturally and linguistically appropriate services for our diverse communities is greatest in Toronto, Markham and Vaughan
- The proportion of Central LHIN's population considered "low-income" is the second highest in Ontario, at almost 18% (Source: IHSP Environmental Scan – MOHTLC Health Analytics Branch August 2012)
- Central LHIN is a fast growing and diverse community, home to 864,00 immigrants and 48% of the population of which English is not their first language (Source: HAB, Health Links Demographics, Census & Utilization Profile, Central LHIN, May 2013). Health care services and supports that meet the needs of our diverse population will impact current system capacity and access to services
- As our population ages, the incidence of chronic disease rises. In Central LHIN, cancer, ischemic heart disease and stroke are the top 3 reasons for hospital admission (Source: HAB, Health Links Demographics, Census & Utilization Profile, Central LHIN, May 2013)
- The increase in the number of our residents over the age of 65, with one or more chronic conditions, will continue to stress all aspects of the health care continuum from acute care, community sectors, long-term care and primary care

Successes:

- Planning underway to establish Health Links in three Central LHIN sub-planning regions: South East York Region, South West York Region and North York West
- Central LHIN CSS agencies have interpretation services available to support up to 4,000 non-English speaking residents (Source: 2013 Central LHIN Community Report)
- Central LHIN providers are encouraged to complete the Health Equity Impact Assessment in order to improve health equity and reduce health disparities for residents
- Completion of Urban Aboriginal Engagement Strategy designed to build trust and rapport with Aboriginal people and the health service providers and social service agencies who care for this population
- Adoption of Entité 4 and the GTA LHINS Joint Action Plan for 2013-14. The objective of the plan is to improve access to French language care, at the right place and the right time in the following priority areas: senior care, mental health and addictions, primary care and clients with chronic conditions

PERSON-CENTREDNESS

Goals & Action Plans

Goal 1: Keep our population healthy

Goal 2: Promote knowledge & self-management of chronic disease

Goal 3: Promote equitable access to health services

Goal 4: Improve the patient experience when accessing health services

Consistency with Government Priorities

Goals support the government priority of Keeping Ontario Healthy!

Action Plans/Interventions

Action Plans	Please indicate the status of the project (Not yet started, in progress, deferred, or completed) and % completion anticipated in each of the next three years		
	2014-15	2015-16	2016-17
Establish a Citizens Health Advisory Panel in Central LHIN to inform health system planning and design from the citizen's perspective	100% Completed		
Expand access to primary care and culturally adaptive mental health and substance abuse services, and chronic disease self-management supports for Aboriginal communities which may include the use of telemedicine and/or telehomecare	10% In progress	30% In progress	60% Completed
Implement evidence-based model to identify and proactively support youth at risk of substance abuse	75% In progress	25% Completed	
Continue engagement with Entité 4 to support additional access to services for the francophone community to improve quality of care and client satisfaction for the Francophone community	33% Ongoing	33% Ongoing	34% Ongoing
Embed patient experience surveys in Health Links evaluation process	75% In progress	25% Completed	

How we will measure success?

- Central LHIN Citizens Health Advisory Panel established
- Options for telemedicine and/or telehomecare in rural Aboriginal communities investigated and implementation plan complete
- Reduce unplanned ER visits for mental health and substance abuse conditions (Central LHIN 2013-14 MLPA targets are 17% and 21% respectively)
- Patient experience surveys embedded into a minimum of two Health Links

What are the risks/barriers to successful implementation?

- Identification and engagement of the appropriate stakeholders to contribute to the continued work with the Aboriginal population
- Multiple change initiatives are underway which may stretch the capacity of health service providers to implement
- Securing primary care support for the promotion of self-management programs and culturally adaptive services

Plan to mitigate risk?

- Clear and frequent communication with Aboriginal elders, community leaders and Central LHIN residents by leveraging Central LHIN's community engagement plan
- Aboriginal cultural competency training for LHIN staff and health service providers
- Encourage health service providers to align with and leverage Health Links
- Continued engagement with Primary Care through Central LHIN primary care physician lead and Primary Care Council

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

- Timely deployment and sustained adoption of eHealth initiatives and tools
- Comprehensive and effective engagement with the community and health service providers
- Enhanced Aboriginal cultural competency across the healthcare continuum
- Health System Funding Reform and strategic investments

4.3 LHIN Operations – Template B

LHIN Operations Sub-Category (\$)	2012/13 Actual *	2013/14 Forecast **	2014/15 Allocation ***	2015/16 Planned Expenses ***	2016/17 Planned Expenses ***
Salaries and Wages ¹	2,413,373	2,994,985	3,244,280	3,244,280	3,244,280
Employee Benefits	461,896	598,997	651,496	651,496	651,496
Total Compensation	2,875,269	3,593,982	3,895,776	3,895,776	3,895,776
Transportation and Communication					
Staff Travel	8,302	8,500	11,000	11,000	11,000
Governance Travel	3,832	5,000	5,000	5,000	5,000
Communications	42,836	35,184	44,220	44,220	44,220
Others	47,500	47,500	47,500	47,500	47,500
Total Transportation and Communication	102,470	96,184	107,720	107,720	107,720
Services					
Accommodation	244,030	265,818	270,517	274,270	279,500
Advertising	33,104	62,283	17,000	17,000	17,000
Consulting and Professional Services	17,160	170,850	137,600	133,600	128,600
Governance Per Diems	51,100	57,200	74,000	74,000	74,000
LSSO Shared Costs ²	343,210	393,431	318,615	318,615	318,615
Other Meeting Expenses	113,407	169,889	197,841	197,841	197,841
Other Governance Costs	8,193	4,625	10,000	10,000	10,000
Printing & Translation	57,439	43,383	54,320	54,320	54,320
Staff Development	39,441	51,689	56,471	56,718	56,488
Total Services	907,085	1,219,168	1,136,364	1,136,364	1,136,364
LHIN Operations Sub-Category (\$)	2012/13 Actual *	2013/14 Forecast **	2014/15 Allocation ***	2015/16 Planned Expenses ***	2016/17 Planned Expenses ***
Supplies and Equipment					
IT Equipment	9,465	28,161	22,000	22,000	22,000
Office Supplies & Purchased Equipment	183,515	118,879	53,170	53,170	53,170
Total Supplies and Equipment	192,979	147,040	75,170	75,170	75,170
LHIN Operations: Total Planned Expense	4,077,803	5,056,374	5,215,030	5,215,030	5,215,030
Annual Funding Target				5,215,030	5,215,030
Variance				-	-

* Includes LHIN Operations only

** Includes LHIN Operations and Diabetes

*** Includes LHIN Operations, Diabetes, FLS and Aboriginal

- 1 Salaries and wages for fiscal 2014/15 include FLS position and no vacancies
- 2 LSSO expenses for fiscal 2014/15 include base costs only with no provision for one-time project expenses

4.3 LHIN Staffing – Template C

Position Title	2012/13 Actual as of Mar 31/13 FTE *	2013/14 Forecast **	2014/15 Forecast FTE ***	2015/16 Forecast FTE ***	2016/17 Forecast FTE ***
CEO	1.0	1.0	1.0	1.0	1.0
Senior Director	1.5	2.0	2.0	2.0	2.0
Director	3.6	4.6	4.6	4.6	4.6
Communications Manager	1.0	1.0	1.0	1.0	1.0
Communications Specialist	1.0	1.0	1.0	1.0	1.0
Corporate Associate	0.8	1.0	1.0	1.0	1.0
Executive Assistant	1.0	1.0	1.0	1.0	1.0
Administrative Assistant	1.0	1.0	1.0	1.0	1.0
Business/Operations Assistant	1.0	1.0	1.0	1.0	1.0
Office Manager	1.0	1.0	1.0	1.0	1.0
Senior Coordinator	2.0	2.0	2.0	2.0	2.0
Planner	1.0	1.0	1.0	1.0	1.0
Senior Decision Support Analyst	0.2	1.0	1.0	1.0	1.0
Decision Support Analyst	-	1.0	1.0	1.0	1.0
Senior Planner	2.4	3.6	3.7	3.7	3.7
Coordinator	1.0	-	-	-	-
Business Analyst	2.0	3.0	4.0	4.0	4.0
Senior Business Analyst	2.0	2.0	2.0	2.0	2.0
Consultant, FLS*	-	-	1.0	1.0	1.0
Quality / Integration Manager	-	-	1.0	1.0	1.0
Total FTEs	23.5	28.2	31.3	31.3	31.3

* Includes LHIN Operations only

** Includes LHIN Operations and Diabetes

*** Includes LHIN Operations, Diabetes, FLS and Aboriginal

4.4 Integrated Communications Strategy – Template D

Business Objectives

Central LHIN's goal is to improve the local health care system – to make it better for those who live, work and receive health care in our LHIN. Our success in achieving that goal depends on working together with our health service providers to develop a plan and help us translate our plan into action. Through the implementation of the Integrated Health Service Plan (IHSP) 2013-2016 and the execution of the Annual Business Plan over the next year, we will be working on advancing quality and excellence in the delivery of services and supports to our community, and building on the momentum we have achieved since our inception.

The communication team will support the implementation of the following objectives by building awareness and working towards influencing attitudes and behaviours around the quality based system directives areas outlined in our 2013-2016 IHSP:

- **Appropriateness:** Improve the delivery of safe, effective and timely care in the right setting.
 - Continue to improve and plan for expansion of eReferral and/or Resource Matching & Referral across the health care continuum
 - Advance Physiotherapy reform as a key component of the Senior's Strategy to prevent functional decline and reduce falls in seniors
 - Expand telemedicine capacity LHIN-wide (consults, tele-stroke and telehomecare)
- **Access:** Continue to improve access to hospital, community and primary care.
 - Implement medical clearance best practices for Mental Health and Addictions Emergency Department (ED) patients
 - Implement the Provincial Life or Limb No Refusal Policy for referral, acceptance and repatriation of clients with a life or limb threatening condition
 - Expand access to community supports for people with complex care needs. Includes implementation of a system-wide process for placing clients in assisted living in support of Ontario's Senior's Strategy and may include supports to address caregiver burnout/respite care
 - Expand access to services and supports for young adults with complex care needs that may also include developmental disabilities
- **Integration:** Strengthen integrated health care delivery from disease prevention and primary care, through community, acute, long-term and end of life care.
 - Implement up to five Health Links in Central LHIN
 - Develop a Central LHIN model to optimize LHIN-funded community-based transportation services
 - Implement Hospice Palliative Care plan to advance high quality and high value palliative care delivery in support of the declaration of partnership between LHINs, the Ministry and the Quality Hospice Palliative Care Coalition of Ontario
- **Person-centredness:** Improve equity in how people experience health care and service delivery.
 - Implement evidence-based model to identify and proactively manage youth at

- risk of mental health conditions and substance abuse
- Continue engagement with Entité 4 to support additional access to services for the Francophone community to improve quality of care and client satisfaction
- Within Health Links, collaborate with the community to promote holistic, cross-sector strategies to address social determinants of health in at risk populations. Embed patient experience surveys in Health Links evaluation process

Communications Objectives

A strong communications strategy and plan are critical to support the execution of our vision of *Caring Communities – Healthier People*. The communications objectives are to:

Raise awareness of:

- Central LHIN's role in Ontario's transformation of the health care system
- The LHIN's strategies and local solutions designed to respond to the health care needs of the people in our communities: northern Toronto, York Region and south Simcoe County
- The key initiatives that are helping Central LHIN achieve its IHSP priorities as outlined in the section above

Inform and update health service providers on the key initiatives within Central LHIN that are improving timely, appropriate access to health care – document successes and share.

Educate and build awareness among health service providers of:

- The shared accountability of the Central LHIN and health service providers in transforming the health system
- The IHSP and alignment with its initiatives within their plans

Demonstrate the value of the Central LHIN to the people in our communities

Proactively manage issues with timely, accurate and relevant information so that key stakeholders and media (when required) are equipped with Central LHIN's position on the item/issue

Context

- Ontario's **Action Plan for Health Care**, announced by the Minister in January 2012, positions LHINs at the centre of health system transformation
- Along with the other LHINs, Central LHIN has a critical role to play in recently introduced key provincial initiatives such as **Health System Funding Reform, Health Links, Seniors Strategy** and the expansion of **Quality Improvement Plans** into the primary and community care sectors
- Central LHIN's vision of *Caring Communities – Healthier People* outlined in **IHSP 2013-2016** and the initiatives laid out in this **Annual Business Plan** are strategically aligned with government directions 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
- The health care system has evolved to the point where LHINs are being recognized as the **local system managers** who play a central leadership role in driving health system transformation

Target Audience

Depending on the situation, primary and secondary audiences will include but not be limited to:

Central LHIN **health service providers and stakeholders** – including Board Chairs and Executive Leads, physicians, clinicians and related health care professionals – of the following:

- Hospitals
- Central Community Care Access Centre (CCAC)
- Long-Term Care (LTC) Homes
- Community Health Centres (CHCs)
- Community Support Service Agencies
- Mental Health and Addictions Agencies
- Central LHIN Advisory Networks and Groups
- Public health
- Primary Care

External stakeholders: Central LHIN residents including the Aboriginal community and Francophones, MPPs, Mayors / Council members / municipal Chief Administrative Officers, and the media

Ministry of Health and Long-Term Care (MOHLTC)

Internal to Central LHIN: Board of Directors, Senior Leadership Team, and staff

Other Target Audiences: French Language Health Planning Entity, provincial medical-community associations and organizations such as the HQO, OMA, OHA, Cancer Care Ontario and others who are able to help deliver messaging to our target audiences and the broader community

Key Messages

1. **Ontario is shifting the focus of its health care system to revolve around the person.**
We have a plan to ensure Ontarians have access to high-quality care and a sustainable health system for years to come. By organizing our system differently and focusing on medical evidence, we will provide Ontarians with better care and better value for tax dollars

Through these changes, we expect to see:

- Reduced wait times and faster access to family doctors
- Fewer unnecessary visits to the emergency room and re-admissions to hospital
- Patients receiving care at home or in the community instead of in a hospital

How are we transforming the health care system?

- Partnering with the sector and enabling them to play an active role in how the system will change
- Strengthening community agencies to support providers and encourage integration around the patient's needs
- Health care funding that's determined based on the best evidence and follows the patient

What can we expect from these changes to the health care system?

- A system built for patients by the health care providers and leaders closest to them
 - A health care system that integrates providers around patients to deliver better outcomes
2. **Central LHIN is a key leader in transforming the health system** to provide quality care that meets the needs of Ontarians today and into the future. We work with our providers and our communities to identify needs, gaps and opportunities for improvement, and respond as best we can so that the people who need care, get it
 3. **LHINs are the only organizations in Ontario that bring together health service providers** from sectors such as hospitals, community support services, community mental health and addictions, community health centres and long-term care to develop innovative, collaborative solutions leading to more timely access to high-quality services for the residents of Ontario and Central LHIN communities. By supporting these important partnerships, LHINs work to enable Ontarians to have access to an effective and efficient health care system that delivers improved health care results and a better patient experience
 4. **Central LHIN is the hinge that brings together health service providers in our region** to develop innovative, collaborative solutions leading to a more coordinated, value-driven model that promotes wellness and a better patient experience. Together, we are changing from an old system designed to treat people once they are sick to a more coordinated model that promotes wellness
 5. **Central LHIN and its providers continue to bring about significant and positive change** to ensure better patient outcomes

Strategic Approach

1. Support the Ontario government's Action Plan for Health Care. Specifically, LHINs have a responsibility in important provincial initiatives such as Health System Funding Reform, Health Links and the Seniors Strategy
2. Position the LHIN as a key player within the transformation of Ontario's health system and as the lead in health system transformation in the northern section of Toronto, York Region and the southern part of Simcoe County
3. Develop and leverage opportunities to further establish our reputation and credibility
4. Leverage proactive communications tactics (e.g. LHINfo minutes, Report to the Community, news releases) to demonstrate the collaborative work that is being done to improve the health system at the local level. Explore the use of social media platforms – such as YouTube and e-newsletters – to further extend the reach of our messages
5. Continue to refine and target website content and navigation through the implementation of a new content management solution (CMS) so that Central LHIN's key accomplishments and areas of focus are clearly defined and easy to access
6. Implement the Ministry's updated visual identity guidelines through online and print materials to achieve a consistent look and feel in Central LHIN's communications materials

7. Develop communications collateral and tools to support staff and Central LHIN's community engagement efforts
8. Employ issues management strategies, as needed, to mitigate potential risks by identifying key stakeholders, key messages and communication vehicles up front
9. The communication plan is a "living document" that will be revised and updated by Central LHIN to accommodate and address any changes, issues or developments
10. The Annual Business Plan will be communicated to the following stakeholders: health service providers, MPPs, municipal mayors / councils, media and the public

Tactics – high level

Tactics and tools will differ for each initiative, drawing from the following:

1. Corporate website / web alerts
2. LHINfo Minutes
3. News releases
4. Email blasts to stakeholders
5. Annual Report to the Community
6. Creation of pamphlets and brochures, as needed, to support engagements
7. Stakeholder events
8. Board Updates
9. Short corporate videos posted to corporate website and on YouTube
10. Introduction of a new e-newsletter
11. Outreach to local government stakeholders
12. Key messages to support local initiatives

Evaluation

Measurement and evaluation enable Central LHIN to determine if our communications objectives have been achieved. This will be accomplished by evaluating tone (of media pickup, stakeholder commentary, etc.), feedback (both positive and negative) and reach (of messaging, scope, etc.), which will help determine success or if a change in direction is needed.

Feedback mechanisms and ongoing assessment are in place to monitor the effectiveness of communication vehicles and messages. These include:

- Engagement session evaluations
- Online surveys
- Website traffic via monitoring tools such as Google Analytics
- Social media monitoring, such as YouTube views and tweets on Twitter
- Media pickup and analysis
- Evaluation of community response to local initiatives and announcements

4.4 Community Engagement – Template E

In accordance with provincial Community Engagement Guidelines and with our obligations under the Local Health System Integration Act, 2006 (LHSIA), Central LHIN is required to develop and publish an annual Community Engagement Plan that aligns with our Annual Business Plan (ABP) priorities and the LHIN's Integrated Health Service Plan (IHSP). Community Engagement helps us assess local needs and plan for local health services through the interaction, sharing and gathering of information from and with our stakeholders to improve the health care system. This summary highlights the community engagement framework and key activities planned by Central LHIN to ensure we achieve the right level of community engagement to support our projects and planning activities outlined in our Annual Business Plan for 2014-15.

Engagement Strategies

Central LHIN supports the concept of a continuum of engagement strategies. Our engagement strategies will fall within this framework, with strategies chosen that will meet our engagement requirements for our projects and planning activities.

Inform and Educate: Provide accurate, timely, relevant and easy to understand information to the community. Provides information about the LHIN, and contextual information regarding issues, alternatives, and/or solutions. **Effect: Information “Push” / No feedback.**

Gather Input: Obtain feedback on analyses / proposed changes. Designed to allow opinion / concerns / suggestions from the community regarding the matter at hand. **Effect: Information “Pull” / Feedback incorporated into final decision or implementation.**

Consult: Actively seeking out and recording of opinion from stakeholders on matters that directly affect them or where they have a significant interest. Envisions a dialogue between the LHIN and stakeholders that will inform final decisions. **Effect: Information “Pull” / Feedback is consultative and interactive and informs outcome.**

Involve/Collaborate: Work directly with stakeholders to ensure full understanding of issues and concerns and/or facilitate discussions to consider options and solutions. Supports collaboration between the LHIN and stakeholders or between groups of stakeholders. Engagement will result in a solution that is largely arrived at through this process. **Effect: Knowledge transfer-exchange / Final outcome a result of engagement.**

Stakeholders

Key to the success of Central LHIN engagement strategies is the active involvement of our stakeholders. Our stakeholders are organizations or people with a strong interest in the outcomes and decisions made by the Central LHIN. Our stakeholders are affected by the decisions we make and are invited to be involved in the engagement process.

Stakeholder priority groups

- **Primary care providers** (physicians, nurse-practitioner led clinics, all physician group practice types, community health centres)
- **Hospitals, Community Care Access Centre, Community Support Services and Mental Health and Addictions agencies, Long Term Care and medical specialists**, as each has a role in keeping our population healthy

- **Aboriginal peoples** and/or representatives of this population either self-identified or identified through the development of our engagement strategy
- Francophones
- **Residents of Central LHIN** as consumers of health care services and supports
- **Stakeholders directly or indirectly involved in Central LHIN projects or activities** as identified through our annual business plan

Committees

Many of our stakeholders are invited to participate in Central LHIN committees with the goal to gather input, consult and collaborate in planning activities and decisions. Central LHIN committees in operation for 2014-15 are as follows:

The Health Professionals Advisory Committee (HPAC) is the only committee required by legislation (Local Health System Integration Act, 2006 or Ontario Regulation 267/07). HPAC was reconstituted further to the completion of an evaluation, and held its first meeting in March 2013. HPAC will continue to provide advice to the LHIN on achieving patient-centred care.

The Health Links System Planning Committee was established in 2013 and is the committee responsible for overseeing and coordinating the implementation of the five Health Links in the Central LHIN and monitoring performance as it relates to client and system outcomes.

The Citizens Health Advisory Panel (CHAP) established in fiscal 2013-2014, gives voice to the community in Central LHIN's system planning initiatives. This Panel will serve as a forum for dialogue amongst community members as they advise the LHIN on how to achieve person-centred health care in designing programs within the local health system context.

The Primary Care Council was established in 2012 to begin to integrate primary care into Central LHIN planning. The committee serves as a conduit for engagement of the primary care community, which currently is under the purview of the province. The committee includes physicians, nurse practitioners and other stakeholders who work within the community health sector.

Emergency Department Working Group This is a working group that is mandated by the Ministry Of Health and Long Term Care Emergency Department Network. Membership includes Emergency Department Directors and Physician Chiefs at all Central LHIN hospitals, CCAC and emergency services. This group meets bimonthly with a mandate to collaborate and share emergency department best practices.

Local Partnership To help foster a change management environment at the local level, 14 Local Partnerships are being formed across Ontario. Each LHIN will form a Local Partnership to help support the successful implementation of Health System Funding Reform (HSFR) outcomes by coordinating a supportive change management environment locally and across Ontario. The Local Partnership will act as an advisory group, facilitating clinical, financial and decision support advice to and from LHINs and the MOHLTC from an implementation and change management perspective. The scope of the Local Partnership surrounds capacity planning, knowledge translation, and issues identification and management. The Local Partnership will have senior representation from the LHIN, hospitals and CCAC.

Central Hospice Palliative Care Program Council Central LHIN is working with the Central Hospice Palliative Care Program Council to advance the objectives established in the Provincial Declaration of Partnership and Commitment to Action: *Advancing High Quality, High Value Palliative care in Ontario*. The mandate of the Council is to provide oversight to the development and implementation of the Regional Hospice Palliative Care Program.

Regional Chronic Disease Prevention and Management Committees Central LHIN participates in several regional chronic disease prevention and management committees including Ontario Stroke Network, Ontario Renal Network, Cancer Care Ontario, Regional Diabetes Committee and Chronic Disease Self- Management, to assist in the sharing of information relevant for health system planning and to identify opportunities for integration of service delivery.

Wait Time Strategic Planning Group This group develops strategies to improve LHIN-wide performance on wait times ultimately to improve access to care for patients in our LHIN.

eHealth Advisory Council Central LHIN's Integrated Health Service Plan 2013-2016 identifies eHealth as a key enabler for achieving the Ministry's priorities and those of the LHIN and its partners. The council is comprised of IT leadership from various sectors of the continuum of care. Its main objectives are to: support the development and implementation of the Central LHIN eHealth Strategic Plan for each year as indicated in the Ministry-LHIN Performance Agreement (MLPA); and provide guidance and advice on eHealth implementations.

2014-15 Engagement Activities

- Annual Business Plan 2015-2016 Collaborative Planning Session
- Quality Improvement Symposium
- Health Link Community Support Services and Mental Health and Addictions Engagement
- Comprehensive and effective engagement with Health Service Providers and stakeholders including engagement of Caregivers and clients to understand care needs, gaps and future opportunities
- Eight resident Community Engagement sessions across the LHIN
- Mental Health and Addictions Engagement
- Family Health Team engagement in Quality Improvement Plan reviews with hospitals, CCAC and Community Health Centres
- Aboriginal Community Engagement
- Entite 4 /Central LHIN Engagement with Association of York Region Francophones
- Francophone Community Engagement

Ongoing Engagement

Engagement of the Francophone Community Central LHIN has approximately 1.2% of its population who identify themselves as francophone. No part of Central LHIN and none of our health service providers are designated under the *French Language Services Act*. The LHIN supports the Francophone population through its participation with Entité 4, the French planning partner for the GTA LHINs. Where practical, Central LHIN supports the provision of French Language Services – such as Central LHIN's fully bilingual website and public materials such as annual report, news releases, etc. available in French – or the capability of translation services, where Francophone populations exist. Entité 4 and the GTA LHINs adopted a Joint Action Plan for 2013/14. The general objective of the plan is to improve access to the right French language care, at the right place and at the right time within the following priority sectors: senior care, mental health and addictions, primary care and patients with chronic conditions. This focus will help

improve the quality and safety of care as well as patients' experiences while reducing the detrimental impact of linguistic and cultural barriers on health system performance.

Engagement of Aboriginal Peoples Aboriginal people represent 0.4% of the LHIN's population. While a portion of this population lives on Georgina Island, the majority of First Nations people in Central LHIN are living off reserve, primarily in semi-rural and smaller communities in south Simcoe County. Central LHIN developed an Off-Reserve, Urban Aboriginal Engagement Strategy in 2013-14, intended to build trust and rapport with Aboriginal peoples through a series of engagement sessions with Aboriginal residents and health service providers both in Central LHIN and in the Greater Toronto Area. The results of the engagement sessions will inform planning for the development of a Central LHIN Aboriginal Health Strategy in 2014-15.

Health Links Key stakeholders will continue to be engaged in the implementation and evaluation of the health links within the Central LHIN.

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