

2015-16 Annual Business Plan

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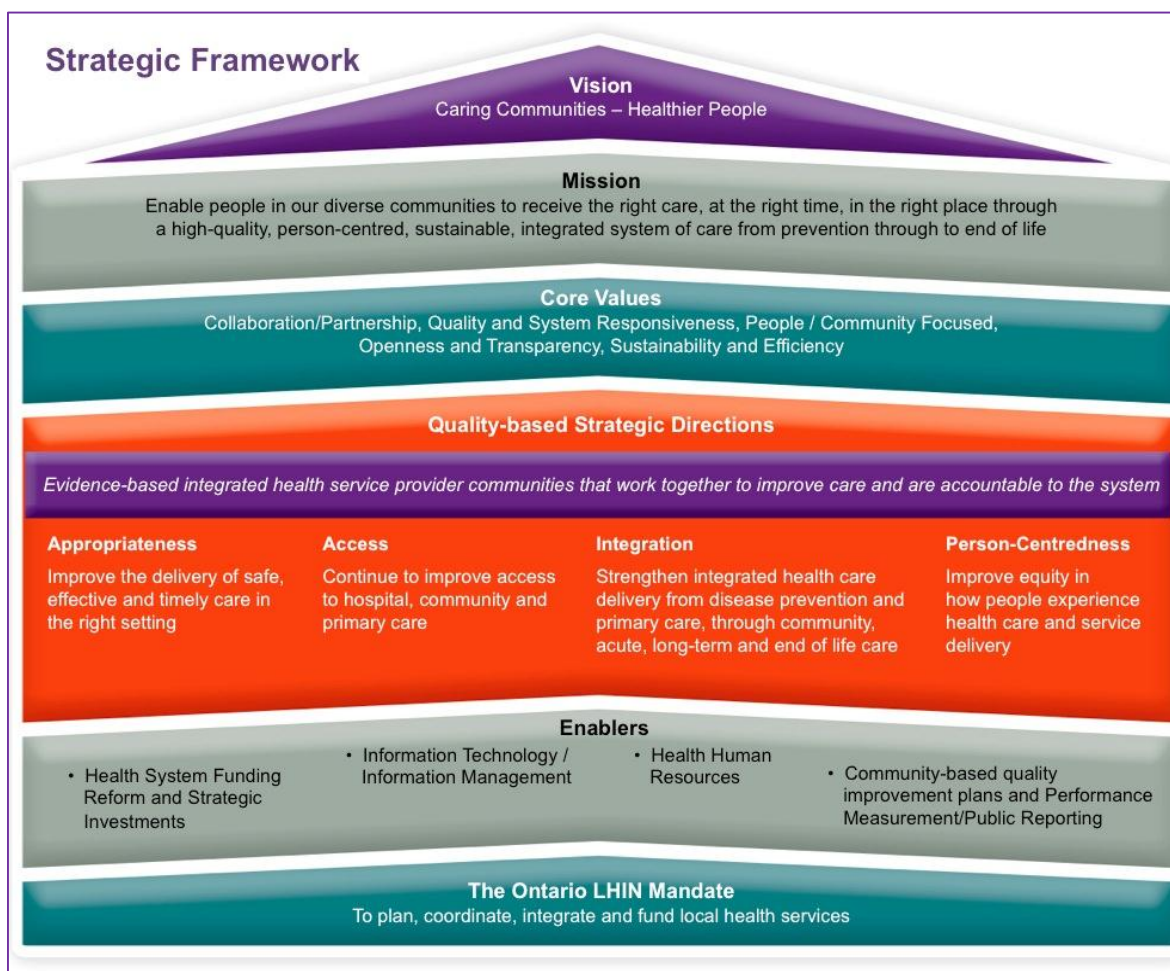
4.1 Context

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**.

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 designed to enable transformation of the system towards a high-performing, sustainable health system grounded in evidence-based practice, enhanced collaboration across sectors, and improvements in the patient or client health care experience. The Central LHIN 2015-2016 Annual Business Plan (ABP) will focus on the third year of the IHSP 2013-2016. The purpose of the ABP is to operationalize the IHSP and determine funding allocations to meet the action plans set out for the upcoming year.

In the development of the ABP, Central LHIN is guided by the 2014 mandate letters to the Minister and Associate Minister of Health and Long-Term Care, covering important priorities in health, long-term care and wellness. Central LHIN is also guided by the provincial priorities outlined in Ontario's *Patients First: Action Plan for Health Care* (February 2015) which targets four priority areas:

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

The Central LHIN 2015-2016 Annual Business Plan (ABP) is a refresh of the last year of our roadmap to align results, highlight 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	6*
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

*In addition, one service accountability agreement with a hospital outside the Central LHIN.

Advancing System Goals

As a guiding document, the 2014-2015 ABP enabled Central LHIN and its Health Service Providers to make advancements in IHSP 2013-2016 priorities, through the following improvements within the local health system:

Appropriateness

- Aligned all Hospital and Community Health Centre Quality Improvement Plans (QIPs) with LHIN priorities. Family Health Teams (FHTs) formally engaged in QIP process for the first time.
- Improved processes for Resource Matching and Referrals (RM&R) as measured by reduced time between referrals and acceptance time for Community Care Access Centre (CCAC) services as well as improved Resource Matching and Referrals user survey results. (Source: Strata IQ Aug 2012 to June 2014, RM&R User Survey, November 2014)
- Achieved Ministry-LHIN Performance Agreement (MLPA) target for percentage Alternative Level of Care (ALC) Days in 2013/14, and in first quarter of 2014/15.
- Followed standardized clinical pathways in all hospitals - for Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and Stroke, to support implementation of Quality Based Procedures (QBP).
- Improved adoption of telemedicine into clinical practice through increased usage and expansion to all Central LHIN Long-Term Care Homes.
- Expanded Central LHIN's Telehomecare program to include two Health Link regions.

Access

- Increased number of primary care practitioners with an Electronic Medical Record (EMR) using Hospital Report Manager (HRM) to view hospital reports to 45% in 2014/15 from 15% in 2013/14. (Source: OntarioMD, Dec 2014)
- Increased number of primary care practitioners with an EMR using Ontario Laboratory Information System (OLIS) to 60% in 2014/15 from 40% in 2013/14. (Source: OntarioMD, Dec 2014).
- Implemented standardized discharge summary template across Central LHIN hospitals to improve consistency of information being sent to primary care practitioners through an electronic connection between hospitals and primary care offices.
- Enabled the first Central LHIN hospital to go live with the regional electronic health record: ConnectingGTA. This enables the hospital to access electronic patient information from over 12 GTA hospitals and five CCACs covering the geographic boundaries of six LHINs.
- Implemented fully the Ministry of Health and Long-Term Care's (MOHLTC) Life or Limb Policy in 2014/15. Patients with life- or limb-threatening conditions will receive medical consultation, and if necessary, will be transferred to an appropriate point of care within a best-effort window of four hours.
- Provided access to Assisted Living Services for 2,034 high-risk seniors, as per the MOHLTC Assisted Living Policy.
- Completed implementation of 385 additional exercise and falls prevention classes for seniors as key components of the Ministry's physiotherapy reform strategy.

Integration

- Implemented third Health Link and completed planning for the last two.
- Began the implementation of a community-based transportation project to optimize transportation services.
- Development is underway of a strategy for a centralized point of client access for the community support services sector, to be implemented in 2015/16.
- Developed an Action Plan (based on the Final Service Change Recommendations from the former Regional Hospice Palliative Care Program Council) for hospice palliative care in the Central LHIN and began implementation of first three action items: Central point of access, one number for crisis calls, enhancing capacity through standardized education.
- Completed two voluntary integrations in accordance with the Local Health System Integration Act (2006).

Person-Centredness

- Established Central LHIN Citizens Health Advisory Panel.
- Investigated and implemented options for telemedicine and/or telehomecare in rural Aboriginal communities.
- Embedded Health Link's client experience surveys into two Health Links processes.
- Completed development of internet based community clinical pathways for COPD and Diabetes.
- Implemented COPD clinics at the two Community Health Centres.
- Enabled all Diabetes Education Programs to have access to telemedicine by the end of fiscal 2014/15.
- Developed patient experience framework to guide patient-centred engagement including creation and deployment of an on-line patient experience survey LHIN-wide in French and English, targeting 6,000 respondents.

Central LHIN has continued to demonstrate progress toward meeting Ministry-LHIN Performance Agreement (MPLA) indicators for emergency room length of stay, surgical wait times, diagnostic wait times and Alternative Level of Care (ALC) days.

Performance Indicator (PI)	Trending (Q2 12-13 to Q2 14-15)
90th Percentile ER Length of Stay (hours) for Non-admitted Complex (CTAS I-III) Patients Wait times for complex cases in the ER are improving	
90th Percentile ER Length of Stay (hours) for Non-admitted Minor Uncomplicated (CTAS IV-V) Patients Wait times for minor cases in the ER are improving	
Percent of Priority IV Cases Completed Within Access Target (84 days) for Cancer Surgery Consistently exceeds provincial target and more cancer surgeries (higher volumes) are being completed within target timeframe	
Percent of Priority IV Cases Completed Within Access Target (90 days) for Cardiac By-Pass Surgery Consistently exceeds provincial target and more cardiac by-pass surgeries (higher volume) are being completed within target timeframe	
Percent of Priority IV Cases Completed Within Access Target (182 days) for Cataract Surgery Consistently exceeds provincial target and more cataract surgeries (higher volume) are being completed within target timeframe	
Percent of Priority IV Cases Completed Within Access Target (182 days) for Knee Replacement Consistently exceeds provincial target and more knee surgeries (higher volume) are being completed within target timeframe	
Percent of Priority IV Cases Completed Within Access Target (28 days) for CT scans More CT scans (higher volume) are being done within target timeframe	
Percentage of Alternate Level of Care (ALC) Days ALC rate is improving	

Data Source: Quarterly Stocktake Report, November 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 the highest number of seniors of all the LHINs in the province by 2021.
Children (0-4 years)		5.6%	Central LHIN has the highest proportion of any LHIN. Central LHIN also had the highest number of births (18,919) of all LHIN regions.
Language		4.5%	The percentage of Central LHIN residents with no knowledge of English or French.
Francophone		1.9%	The percentage of our population who are Francophone.
Aboriginal		0.4%	The percentage of our residents who are Aboriginal, with the majority of these living in urban centres.

Source: IHSP Environmental Scan – MOHLTC Health Analytics Branch August 2012; 2011 Census IDF by Census Subdivision (Office of Francophone Affairs); 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 the southern part of Simcoe County. Central LHIN's population is projected to grow at a rate of 20.3% from (2012-2021), making Central LHIN one of the fastest-growing LHINs in the province. A rapidly growing population brings increased care needs for our residents.

Evolving drivers impacting the health system within the Central LHIN include:

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

The impact of an aging population across Ontario has resulted in an increasing number of seniors who require more health services. Central LHIN residents, including seniors, with complex care needs require ongoing support and access to health care, 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 Senior Friendly Hospital Strategy; implementation of a regional hospice palliative care plan; expansion of community chronic disease programs, 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 of higher acuity on the Canadian Triage Acuity Scale (CTAS). This is an indication of the ongoing increases in demand placed on Central LHIN health service providers. *(Source: Directory of Networks ER CTAS Hospital Level Comparison Report, 201403)*

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 communities and 89% living in large urban centres. The ability to deliver care in rural settings presents challenges to receiving the right care, at the right time and in the right place, closer to home. The development and implementation 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. *(Source: Health Analytics Branch: Health Links demographic, census, and utilization profile: May 2013)*

Addressing health care needs of diverse communities

The Central LHIN is a diverse community with the highest proportion of immigrants in the province. *(Source: IHSP Environmental Scan – MOHLTC Health Analytics Branch August 2012)* 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 will 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 zero to four of all of the LHINs. Central LHIN also has the second highest number of children with medical complexity in the province. Going forward, it will be important to address capacity needs for health services for all residents, both young and old. *(Source: ICES, January 2012)*

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 six public acute care hospitals, two private hospitals, 46 Long-Term Care Homes (LTCH), 54 community agencies including two Community Health Centres (CHCs) and a Community Care Access Centre (CCAC) which support clients in the community and in their home. Central LHIN also funds some services in a hospital of another LHIN that serve residents in our LHIN.
- A variety of hospital programs support frail seniors and patients with complex conditions after discharge from hospital. For example, these programs include: Nurse Led, Geriatric and Mental Health Outreach Teams; Hospice Palliative Care Teams; and Rapid Response Nurses.
- In 2013/14: 550,000 patients were seen in Central LHIN emergency departments; 114,000 patients were discharged from hospital, and hospital-based outpatient services provided almost 1.5 million patient visits. Central LHIN community agencies (including community support services, mental health and addictions services and Community Health Centres) served over 67,000 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 2013-14, Central CCAC served 78,000 individuals, up from 72,000 in 2012/13. *(Source: MOHLTC HIT tool)*

- Central LHIN works in partnership with five 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 two Community Health Centres and three hospitals. Approximately 17,000 clients a year receive care at a Central LHIN DEP. *(Source: Central LHIN funded Diabetes Education Program 2014-17 M-SAAs)*
- Clinical telemedicine consults are available to residents throughout the Central LHIN in hospitals, the community sector, long-term care homes and primary care resulting in timeliness to accessing service.
- Central LHIN expanded its telehomecare program in 2014-15 by providing service in two additional Health Link regions. Telehomecare has emerged as a client-centred 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 standardized evidence-based care pathways for Stroke, CHF and COPD across all Central LHIN hospitals.
- Between 2013-2015, Central LHIN increased assisted living for high-risk seniors' spaces by 2,034.
- In 2014-15, Central LHIN staff worked collaboratively with health service providers and the Ministry of Community and Social Services (MCSS) to discuss the support of additional congregate care for young adults with medical complexities and developmental disabilities.

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 community capacity for seniors with complex conditions resulting in more Alternative Level of Care (ALC) days (e.g. the frail elderly with behavioural conditions such as dementia).
- A fragmented palliative care system that could benefit from improved coordination. *(Source: Advancing High Quality, High Value Palliative Care in Ontario Declaration of Partnership, 2011)*

Successes:

- Of the 15 MLPA indicators, Central LHIN has exceeded its target in 11 indicators. Central LHIN has also exceeded the provincial performance in 12 indicators and ranks first among all LHINs for four of the 15 indicators. *(Source: MOHLTC Quarterly Stocktake Report; November 2014)*
- ALC performance remains a top priority of hospitals. ALC performance has improved and Central LHIN's percentage of ALC days was below its target of 15%. *(Source: MOHLTC Quarterly Stocktake Report; November 2014)*
- Expanded Central LHINs Telehomecare program to the North York Central Health Link. Implemented telemedicine capacity in all 46 Central LHIN Long-Term Care Homes.
- Implemented Resource Matching and Referral (RM&R) reporting and analytics framework and tool, enabling outcome analysis and a better understanding of barriers to service.
- Two hospitals (Southlake Regional Health Centre and Mackenzie Health) integrated their Hospital Information Systems with the Resource Matching and Referral Tool which significantly reduced duplicate data entry and the time to complete a referral (500 hours of clinical time saved per site). *(Source Strata Health Case Study: Central LHIN hospital reduce duplicate data entry and improve clinician satisfaction)*

- Central LHIN partnered with Health Quality Ontario (HQO) to provide education sessions to Long-Term Care Homes in preparation for their 2015-16 QIP submissions.
- In 2014-15, Central LHIN facilitated discussions with GTA LHINs and the Hospital for Sick Children to enable community hospitals to provide more paediatric care closer to home.

2015/16 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 evidence-based decision making

Consistency with Government Priorities

The above goals align with Ontario's focus on keeping people healthy and providing the right care, at the right time, in the right place.

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.		
	2015-16	2016-17	2017-18
Strengthen the alignment between Hospital, CCAC, LTCH, and Community Health Centre Quality Improvement Plans (QIPs) and LHIN priorities. Engage Family Health Teams and Nurse Led Practitioner Clinics in alignment review.	100% Completed		
Expand telemedicine capacity LHIN-wide. This includes increasing adoption of telemedicine in clinical practice (i.e. Diabetes, COPD and Stroke clinics, LTCH and Hospitals) and expanding Central LHIN's Telehomecare program into additional Health Links.	20% In progress	20% In progress	60% Complete
Improve system capacity, coordination and care processes to reduce ALC pressures and wait times for complex clients within Central LHIN hospitals and the community.	33% In progress	33% In progress	34% Complete
Implement evidence-based care pathways (Quality Based Procedures) as per the MOHLTC schedule (e.g. hip fracture). This work may include the community portion of the pathways.	33% In progress	33% In progress	34% Complete

How we will measure success?

- All Hospital, Long-Term Care Home and Community Health Centre QIPs align with LHIN priorities. All Central LHIN Family Health Teams and Nurse Led Practitioner Clinics engaged in QIP review.
- Achieve MLPA target for percentage ALC (15%, baseline for Q1 14/15 is 13.79 %.) (Source: MOHLTC Quarterly Stocktake Report; November 2014)

- Quality Based Procedures (QBP) implemented as per MOHLTC schedule.
- Long-Term Care Homes achieve target for number of telemedicine events based on one event per bed per year. Telehomecare to expand to include one additional Health Link.
- Achieve MLPA target for 30 Day Readmission Rate for selected Case Mix Groups (CMGs) (15%, baseline for Q4 13/14 is 15.96%). (Source: MOHLTC Quarterly Stocktake Report; November 2014)
- Development of a strategy for the Home and Community Care Coordination and Personal Support Services for implementation by 2017.

What are the risks/barriers to successful implementation?

- Willingness of Family Health Teams (FHTs) and Nurse Led Practitioner Clinics (NLPCs) to align Quality Improvement Plans with LHIN priorities. FHTs and NLPCs are not accountable to the LHIN.
- Insufficient capacity of appropriate community alternatives available for our aging population and clients with complex conditions and specialized care needs.
- Telemedicine is a different way of providing clinical care – sustaining implementation in LTCHs.

What is the plan to mitigate risk?

- Engagement of FHTs through Association of Family Health Teams of Ontario (AFHTO) representatives, the Primary Care Council through the Primary Care Physician LHIN Lead and the Nurse Practitioners through the Nurse Practitioner Association of Ontario (NPAO).
- 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, and support appropriate transition of Alternate Level of Care (ALC) patients into the community.
- Support implementation of the telemedicine community of practice within long-term care homes, monthly meetings open to all telemedicine coordinators in Long-Term Care Homes.

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.
- 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. Samir Sinha's 2012 Report "*Living Longer, Living Well.*"
- Aligning Assess and Restore programs and initiatives with the MOHLTC guidelines.
- Collaborating with the MOHLTC in planning 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 services need to 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 eight emergency department sites and one urgent care centre.
- Within Central LHIN hospitals, there are 179 inpatient adult mental health beds and 18 inpatient child/adolescent mental health beds. *(Source: MOHLTC HIT Tool, 2013-14)*
- Central LHIN has 11 family health teams (FHT), two Nurse Led Practitioner Clinics (NLPCs), over 1400 family physicians and over 1200 specialists. *(Source: Central LHIN 2013 Community Report)*
- From February 2009 to March 2014, over 17,000 Central LHIN residents that needed a primary care practitioner were connected to a FHT or NLPC. *(Source: The Quarterly, Health analytics Branch, MOHLTC, Issue 12)*
- Partnerships between our community agencies, 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, additional assisted living for high-risk seniors became available; additional support services for people living with an Acquired Brain Injury (ABI) was provided; enhanced capacity was introduced so that Long-Term Care Homes can support people with behavioural challenges; additional assisted living supports were provided for young adults with medical complexities. Also provided was increased access to supports within housing; crisis support and peer support for those with mental health and addictions challenges.

- 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, supports within housing, vocational support, concurrent disorders, opioid addiction and problem gambling. The agencies served over 13,200 individuals in 2013-14. *(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 long-term care can be required for elderly or frail patients who have experienced significant functional decline as the result of an acute illness. In 2013-14, 907 patients from hospital were transferred to Long-Term Care Homes in Central LHIN. *(Source: Central CCAC Dashboard, Long Term Care Patients Placed by Location Before Placement, November 2014)*
- 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 procedures including: 19,687 MRI hours, 183 joint replacements, 11,877 CT hours, 323 general surgeries and 86 pediatric surgeries. *(Source: Central LHIN 2013-14 Wait Times Tracking Report)*

Key Issues:

- Central LHIN emergency departments see one of the largest proportions of high acuity patients. In fiscal year 2013-14, Central LHIN has ranked as the third highest LHIN in the province in terms of higher acuity ER visits (CTAS 1, 2 or 3). *(Source: Directory of Networks - ER Fiscal Year Report)*
- High-needs patients, including those with mental health conditions, have multiple chronic conditions and co-morbidities, 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 the challenging behaviours associated with mental health, addictions, dementia or other neurological conditions.
- Limited access to services and supports for caregivers to reduce burnout and the need for crisis support for ailing family members.
- Lack of supported, affordable housing for those with mental health and addictions challenges.

Successes:

- Central LHIN is ranked first in the province for having the highest percentage of 'Priority 4' cases completed within the access targets for Cancer, Cardiac By-Pass and Cataract surgeries and ranked second in the province for Knee Replacement surgery. *(Source: MOHLTC Quarterly Stocktake Report; November 2014)*
- Central LHIN is ranked first in the province for having the shortest ER length of stay for non-admitted minor/uncomplicated patients. *(Source: MOHLTC Quarterly Stocktake Report; November 2014)*
- Central LHIN is ranked second in the province for having the second shortest time to see a physician for an initial assessment in the ER. *(Source: MOHLTC Quarterly Stocktake Report; November 2014)*
- Central LHIN is ranked second in the province for having the second lowest number of ER unscheduled visits/1000 population. *(Source: MOHLTC Quarterly Stocktake Report; November 2014)*
- The Behavioural Support Unit at Cummer Lodge - a service for seniors with cognitive impairment - is fully operational and has an occupancy rate of 98%. *(Source: CLHIN BSU Evaluation Dec, 2014)*
- In 2014-15, Central LHIN funded community programs to: support community mental health and substance abuse case management, crisis services, and peer support, Indigenous Cultural Competency Training, Acquired Brain Injury (ABI) support services, and personal support and attendant outreach services.

- Central LHIN funded an expansion of access to community supports for young adults with medically complex care needs. This is a joint initiative between the Ministry of Community Social Services and the Central LHIN. This initiative will be implemented in 2015-16.
- All six Central LHIN hospitals completed development of a process to share mental health beds, including the development of a draft medical stability checklist.
- Central LHIN's early adopter hospital for ConnectingGTA, central Ontario's regional electronic health record, went live. This hospital now has access to electronic patient information from over 12 facilities covering the geographic boundaries of six LHINs.
- Implementation completed for the Integrated Assessment Record (IAR) in Long-Term Care Homes. IAR, a secure centralized assessment repository, has now been implemented in all in-scope agencies in Central LHIN.
- York Regional Police, York Region Emergency Medical Services, and York Region Housing and Social Services have worked together with consumer survivors and Central LHIN through a co-design process to develop a new model of onsite mobile crisis response for York Region.
- Central LHIN developed a vision care strategy that optimized a two-site model that aligned with the provincial vision care strategies.

2015/16 Goals & Action Plans

Goal 1: Continue to streamline the flow of people through hospitals to make the best use of resources (i.e. Nurse Led Outreach Teams, Rapid Response Nurses, Home First and Community CCAC Clinics)

Goal 2: Improve access to primary care

Goal 3: 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

The goals support the Ministry's priority of faster access and a stronger link to primary 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.		
	2015-16	2016-17	2017-18
Complete implementation of medical stability best practices in Central LHIN emergency departments for people with mental health and addictions (MH&A) conditions.	100% Complete		
Implement an integrated ophthalmology service delivery model that focuses on excellent patient outcomes, ease of access, and maximum patient satisfaction.	50% Complete	50% Complete	

Expand access and integration for community mental health and addiction services, including expansion of mobile crisis teams in collaboration with police services and Emergency Medical Services; and development of a MH&A supports within housing strategy in collaboration with Ministry of Municipal Affairs and Housing and the municipalities.	33% In progress	33% In progress	34% Completed	
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How will we measure success?

- Continued improvement in 90th percentile Emergency Room (ER) length of stay for Admitted patients; achieve MLPA target (LHIN target: 30 hours, baseline Q2 14/15 is 28.35 hours).
(Source: MOHLTC Quarterly Stocktake Report; November 2014)
- Reducing the number of police apprehensions for 9-1-1 “emotionally disturbed persons” calls.
- Reducing the number of 30-day Emergency Department (ED) visits for mental health and substance abuse.
- Providing all low-risk ophthalmology services at the two high volume regional eye care centres within the LHIN.

What are the risks/barriers to successful implementation?

- Multiple change initiatives are underway which may stretch the capacity of health service providers to implement and sustain new initiatives.
- Timely deployment of eHealth initiatives is required to support increased adoption and coordination of the various provincial electronic tools.
- Lack of affordable and social housing supply in York Region and North York.
- Timeliness of transfers of ophthalmology patients to the high volume centres.

What is the plan to mitigate risk?

- Continue to work closely with the eHealth provincial teams on strategic project phasing. Utilize LHIN physician leadership to engage physicians and encourage buy-in with electronic tools.
- Work with key housing stakeholders in the development of the MH&A Supports within Housing Strategy.

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. Including continued engagement of caregivers and clients to understand care needs, gaps and future opportunities.
- Timely deployment and sustained adoption of eHealth initiatives and tools.

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 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 (CCAC) which support clients in the community and in their home.
- The early adopter South Simcoe Northern York Region Health Link and North York Central Health Link have been operational for a full fiscal year. Each Health Link is comprised of community, mental health and addictions, primary care, and hospital partners as well as patients, caregivers and other key stakeholders. As of the end of Q2 2014-15, 284 patients with complex needs were enrolled in the two early adopter Health Links. The South West York Region Health Link began implementation prior to the end of Q3.
- 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 eight nurses providing 24/7 palliative pain and symptom management services. In 2013-14 the HPC team received 1,283 referrals. There are 11 visiting hospices in Central LHIN that provide visiting palliative care services through a network of approximately 900 volunteers. In 2013-14 these visiting hospices served 1,500 individuals.
- In addition, there are two residential hospices with a total of seven palliative care beds in operation. A 10-bed residential hospice for York Region to be sited at Southlake Regional

Health Centre is in the planning process. In addition, Toronto Commandery Hospice has now secured a site for a further 10-bed residential hospice in the Central LHIN region within the City of Toronto. Both have been approved by the Ministry with expected implementation dates of summer 2016. Central CCAC provides palliative care support for clients across Central LHIN at home and in residential hospices. In 2013/14, Central LHIN invested almost \$26 million to support end-of-life care in a variety of settings including visiting hospices, residential hospices, in-home support, and community care coordination. Also in 2013/14, Central LHIN funded the CCAC over \$12 million (included in \$26M) to provide over 214,000 hours of in-home end-of-life care. Over 2,000 patients that preferred to die at home had the supports they needed to remain home for the final days of their life. *(Source: HPC Teams and 2014 M-SAA data, key messages)*

- Central LHIN is in the process of implementing the Central LHIN Hospice Palliative Care Action Plan, based on the recommendations from the Regional Hospice Palliative Care Program Council. The Action Plan will deliver on the establishment of a hospice palliative care system for Central LHIN, including the delivery of care in a more consistent, integrated and coordinated fashion by providers working in local communities. The LHIN is in the process of establishing provider and other stakeholder engagement structure as well as a Central Hospice Palliative Care Patient and Caregiver Advisory Committee to advise the LHIN.
- 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.
- Two voluntary integrations were completed in accordance with the Local Health System Integration Act (2006):
 - Circle of Care, a Central LHIN community service sector Health Service Provider (HSP) and Mount Sinai Hospital in Toronto Central LHIN formalized a service partnership to create a comprehensive and integrated continuum of care that follows the patient from home to hospital and back home.
 - ABI Possibilities, a Toronto Central LHIN HSP specializing in community support services for persons with acquired brain injury merged services and operations with PACE Independent Living Inc., a Central LHIN HSP enabling the enhancement of seamless community-based support services for persons living with physical disabilities and acquired brain injury.

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 Information Technology 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. Furthermore, 29% of primary care physicians in Central LHIN do not use an EMR. *(Source: Ontario MD)*
- A fragmented system for clients requiring end-of-life care, including accessing the right care, at the right time and right place of care.
- Lack of predictive tools to identify people in the community in need of additional health care supports and services before an acute event occurs.

Successes:

- Three Health Links are operational.

- Engagement of public health, emergency management services and primary care into Health Links planning to strengthen integration across sectors.
- Substantially completed plan for Centralized Point of Patient Access in the Community Support Services sector.
- As an interim solution, implemented the Health Links Coordinated Care Plan (CCP) in the CCAC's information system Client Health & Related Information System (CHRIS) in order to facilitate distribution of the care plan to members of the client's circle of care.
- The Regional Hospice Palliative Care Program Council submitted their Final Service Change Recommendations based on the Declaration of Partnership and Commitment to Action. The Central LHIN developed an Action Plan to move forward with the implementation of the recommendations over a three-year period (2014-17). Implementation started for Phase 1 of the Central LHIN Hospice Palliative Care Action Plan. A co-design process that includes caregivers/families is being used for the development of a model for centralized access for palliative and end-of-life care and a single Palliative Care Crisis Line. Investments are also being made in education to strengthen knowledge and capacity.

2015/16 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.		
	2015-16	2016-17	2017-18
Increase use of provincial electronic tools to share information across providers. May include electronic hospital reports, consult solutions, Referral and Resource Matching solutions, coordinated care tools and centralized repositories of clinical information for access by multiple providers. (Project will not be completed within this three-year time horizon).	25% In progress	25% In progress	25% In progress
Complete implementation of planned Health Links in Central LHIN	90% In progress	10% Completed	
Further to the recommendations of the Regional Hospice Palliative Care Program Council, implement relevant	33% In progress	33% In progress	34% Completed

phases of the Hospice Palliative Care Action Plan				
Complete the implementation of the regional model for LHIN-funded community-based transportation services	50% In progress	50% Completed		
Implement the strategy for centralized access in the community support services sector	50% In progress	50% Completed		

How we will measure success?

- Determine future expansion of Resource Matching and Referral (RM&R) within Family Health Teams (FHTs) by using lessons learned to make an informed decision on strategy to expand and therefore determining future expansion of RM&R.
- Complete implementation of five planned Health Links in Central LHIN.
- Increased capacity of community-based transportation.
- Reduce 30 Day Readmission Rate for selected Case Mix Groups (CMGs) – 15% baseline is Q4 13/14 is 15.96%. (Source: MOHLTC Quarterly Stocktake Report; November 2014)
- Reduce the total number of acute hospital days attributed to palliative care in a hospital by 10% by 2016/17.
- Increase adoption of Hospital Report Manager (HRM) from 45% of primary care practitioners with an Electronic Medical Record (EMR) to 70%.
- Increase adoption of Ontario Laboratory Information System (OLIS) from 40% of primary care practitioners with an EMR to 70%.
- Implementation of the Coordinated Care Tool (CCT) in Health Links in accordance with the Ministry's CCT rollout schedule.
- ConnectingGTA going live in two additional hospitals for a total of three hospitals in Central LHIN by March 2016.

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 difficult.
- Timeliness and availability of technology infrastructure, integration and tools to support communication across providers for clients.
- Acceptance of new models of care recommended as a result of the regional Hospice Palliative Care Action Plan.

What is the plan to mitigate risk?

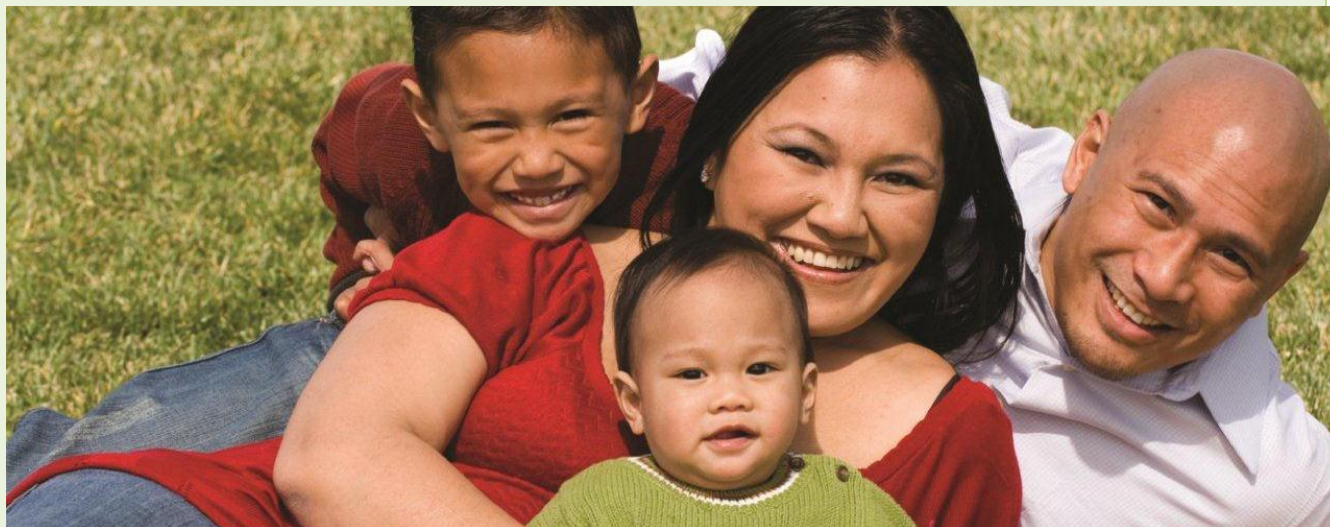
- Clear and frequent communication with providers and other stakeholders to prioritize LHIN initiatives.
- Encourage health service providers to align with and leverage Health Links. Includes developing reasonable implementation plans for priority initiatives.

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 the Hospice Palliative Care Plan with the Health Links model.
- 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).

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.
- 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 2013-14 Central LHIN hospitals had over 12,000 visits to outpatient child and adolescent mental health clinics and eating disorder clinics. Central LHIN community and mental health agencies provided 95,000 case management visits and almost 208,000 visits for various mental health and addiction services. *(Source: MOHLTC HIT tool)*
- All Health Links have embedded the patient experience into their planning and governance structure.
- The Central LHIN Health Links System Planning Committee recruited two patient/caregiver members.

Key Issues:

- Central LHIN's planning areas are different; each has unique challenges and needs that have to be considered when planning at a system level.
- The need to provide culturally- and linguistically-appropriate services for our most diverse communities 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 864,000 immigrants (48% of the population for which English is not their first language). Health care services and supports that meet the needs of our diverse population will impact current system capacity and access to services. (Source: HAB, Health Links Demographics, Census & Utilization Profile, Central LHIN, May 2013)
- As our population ages, the incidence of chronic disease rises. In Central LHIN, cancer, ischemic heart disease and stroke are the top three 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:

- The South West York Region Health Link was implemented and planning completed for the final two planned Health Links in Central LHIN – South East York Region and North York West.
- The Central LHIN funded the full implementation of the evidence-based model "From at Risk to at Promise" to identify and proactively support 280 youths at risk of substance abuse.
- Central LHIN Community Support Services (CSS) agencies have interpretation services available to support up to 4,000 non-English speaking residents. There is a need to continue to improve and build capacity for interpretation services. (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 – relationship development with the Urban Aboriginal community is on-going.
- Central LHIN funded Indigenous Cultural Competency Training for 166 staff members in LHIN-funded health service provider organizations (including Diabetes Education Programs, Mental Health and Addictions programs, Hospitals and Community Health Centres).
- Adoption of Entité 4 - a Joint Action Plan for 2014-15. 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.

2015/16 Goals & Action Plans

Goal 1: Keep our population healthy

Goal 2: Promote knowledge and 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		
	2015-16	2016-17	2017-18
Expand Indigenous Cultural Competency Training to increase access to culturally-adaptive mental health and substance abuse services; and continue to expand chronic disease self-management supports for Aboriginal communities.	25% In progress	25% In progress	50% Completed
Collaborate with Entité 4 to develop a process to increase access to Mental Health & Addictions supports for Francophone residents in Central LHIN.	50% In progress	50% Completed	
Implement a Patient Experience Survey to capture the patient's voice and how patients experience the system; and strengthen patient, family and caregiver engagement in LHIN planning initiatives.	50% In progress	50% Completed	
Develop a strategy to create and manage bed capacity within Long-Term Care Homes within the Central LHIN.	75% In progress	25% Completed	

How we will measure success?

- Reduce unplanned ER visits for mental health and substance abuse conditions (Central LHIN 2013-14 MLPA targets are 17% and 21% respectively).
- Embed client experience surveys (through interviews) into remaining Health Links.
- Engage Long-Term Care Home providers in the development of a comprehensive bed strategy.

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.
- During the Long-Term Care Home redevelopment project announced by the MOHLTC, there is potential for a reduction in Long-Term Care Home bed capacity within Central LHIN which would create further pressure on the health care system.

What is the 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.
- Indigenous Cultural Competency Training for LHIN staff and health service providers.
- Continued engagement with Primary Care through Central LHIN primary care Physician Lead and Primary Care Council.
- Engage GTA LHINs in coordinating Long-Term Care Home redevelopment.

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

- Comprehensive and effective engagement with the community and health service providers.
- Enhanced Aboriginal cultural competency across the health care continuum.

4.3 LHIN Operations and Staffing – Templates B & C

Template B

LHIN Operations Sub-Category (\$)	2013/14 Actual *	2014/15 Actual*	2015/16 Allocation **	2016/17 Planned Expenses **	2017/18 Planned Expenses **
Salaries and Wages	3,081,362	3,356,490	3,433,914	3,433,914	3,426,034
Employee Benefits	600,778	656,026	686,783	686,783	685,326
Total Compensation	3,682,140	4,012,515	4,120,697	4,120,697	4,111,360
Transportation and Communication					
Staff Travel	10,141	18,103	14,980	14,980	14,980
Governance Travel	3,239	2,870	6,000	6,000	6,000
Communications	37,811	34,169	55,000	55,000	55,000
Others	47,500	44,063	50,000	50,000	50,000
Total Transportation and Communication	98,691	99,205	125,980	125,980	125,980
Services					
Accommodation	366,694	262,695	344,117	328,001	337,338
Advertising	61,370	19,469	17,000	17,000	17,000
Consulting and Professional Services	180,222	118,913	25,000	25,000	25,000
Equipment Rentals		-	-		
Governance Per Diems	54,200	37,375	60,000	60,000	60,000
LSSO Shared Costs	375,858	324,496	321,072	321,072	321,072
Other Meeting Expenses	116,595	88,089	80,660	80,660	80,660
Other Governance Costs	6,112	24,315	12,000	12,000	12,000
Printing & Translation	40,936	35,388	62,080	62,080	62,080
Staff Development	39,216	28,678	41,000	41,000	41,000
Total Services	1,241,203	939,417	962,929	946,813	956,150
Supplies and Equipment					
IT Equipment	25,739	43,281	20,000	20,000	20,000
Office Supplies & Purchased Equipment	71,404	83,551	85,424	101,540	101,540
Total Supplies and Equipment	97,143	126,832	105,424	121,540	121,540
LHIN Operations: Total Planned Expense	5,119,177	5,177,969	5,315,030	5,315,030	5,315,030
Annual Funding Target				5,315,030	5,315,030
Variance				-	-
ABP Included all base funded programs					
*Includes LHIN Operations, Diabetes, FLS and Aboriginal (\$5,215,030)					
** Included LHIN Operations, Diabetes, FLS, Aboriginal, and ED/ALC Performance Lead (\$5,315,030)					

Template C: LHIN Staffing Plan (Full-Time Equivalents)

Position Title	2013/14 Actual as of Mar 31/14 FTE *	2014/15 Actual*	2015/16 Forecast FTE **	2016/17 Forecast FTE **	2017/18 Forecast FTE **
CEO	1.0	1.0	1.0	1.0	1.0
Senior Director	2.0	1.8	2.0	2.0	2.0
Director	5.0	4.8	4.5	4.5	4.5
Communications Manager	1.0	0.8	1.0	1.0	1.0
Communications Specialist	1.0	1.0	1.0	1.0	1.0
Corporate Associate	1.0	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	-	-	-
Business/Operations Assistant	1.0	1.0	1.0	1.0	1.0
Office Manager	1.0	0.8	-	-	-
Human Resources Coordinator	-	0.3	1.0	1.0	1.0
Senior Coordinator	2.5	2.5	2.0	2.0	2.0
Planner	1.0	1.0	1.0	1.0	1.0
Senior Decision Support Analyst	0.8	1.0	1.0	1.0	1.0
Decision Support Analyst	1.0	1.0	1.0	1.0	1.0
Senior Planner	3.1	3.7	4.4	4.4	4.4
Financial Analyst	-	1.0	1.0	1.0	1.0
Business Analyst	2.0	3.0	3.0	3.0	3.0
Senior Business Analyst	2.0	2.0	2.0	2.0	2.0
Consultant, FLS	1.0	0.8	1.0	1.0	1.0
Quality / Integration Senior Lead	-	0.3	1.0	1.0	1.0
Total FTEs	28.4	30.8	30.9	30.9	30.9
ABP Included all base funded programs					
*Includes LHIN Operations, Diabetes, FLS and Aboriginal (\$5,215,030)					
** Included LHIN Operations, Diabetes, FLS, Aboriginal, and ED/ALC Performance Lead (\$5,315,030)					

4.4 Integrated Communications Strategy – Template D

Business Objectives

The vision for Central LHIN is to create ***Caring Communities – Healthier People***. We are advancing this goal through our Mission to “enable people in our diverse communities to receive the right care, at the right time, in the right place through a high-quality, person-centred, sustainable, integrated system of care from prevention through to end-of-life.”

Ultimately what this means is an improvement in our local health care system for all those who live, work and receive health care services within our LHIN. Our success in achieving our goals depends on working together with our health service providers, patients and caregivers to develop a plan – and translate our plan into transformative action.

The Integrated Health Service Plan (IHSP) 2013-2016 - and from this, the Annual Business Plan – are key strategic documents that guide our work. They provide the framework to help us advance continued quality and excellence in the delivery of services and supports to our community.

The communication team will support the ongoing implementation of annual objectives that move forward our four Quality-Based Strategic Directions:

- **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.
- **Integration:** Strengthen integrated health care delivery from disease prevention and primary care, through community, acute, long-term and end-of-life care.
- **Person-centeredness:** Improve equity in how people experience health care and service delivery.

Communications Objectives

For 2015/16, the Communications team will develop an integrated communication strategy. We will:

- Strive to reflect the patient and caregiver experience through the voices of those who receive and who give care. This is the lens for how we see the future of patient care – and therefore should inform how we communicate.
- Communicate and engage with our funded and non-funded partners so they can better understand the context, content and reasons for ongoing changes, and implications for both the sector and the system.
- Support the successful implementation of our transformational projects (working titles are: Mental Health and Addiction Supports within Housing; Hospice Palliative Care; Creating Community Capacity and the Capital Redevelopment of Long-Term Care Homes) through communication deliverables deployed to: create awareness; identify and respond to issues; recognize stakeholder contributions; and celebrate success.

Provincial Context

Ontario's health care system is in the midst of an accelerated and sweeping process of change. Specific priorities for health care were articulated as part of the series of Mandate letters written

by the Premier to each Cabinet Minister on September 25, 2014. The Mandate letters outline specific Ministry priorities which will shape provincial and local initiatives into the future.

- The Mandate Letter to the Minister of Health and Long-Term Care identifies these three priorities:
 - *Putting Patients at the Centre — the Right Care, Right Place, Right Time*
 - *Moving Forward on Accountability and Transparency*
 - *Collaborating on Shared Responsibilities across Government*
- The Mandate Letter to the Associate Minister of Health and Long-Term Care (Long-Term Care and Wellness) identifies these four specific priorities:
 - *Modernizing and Improving Long-Term Care Facilities*
 - *Moving Ahead on Health and Wellness Initiatives*
 - *Developing a Health and Wellness Strategy*
 - *Collaborating on Shared Responsibilities across Government*

When Ontario's **Action Plan for Health Care** was announced in January 2012, the plan positioned LHINs at the centre of health system transformation. The second phase of the plan – **Patients First** – was announced on February 2, 2015 and moves the health care agenda forward by strengthening the province's commitment to put people and patients first.

The Central LHIN's strategic priorities and current initiatives are well-aligned with **Patients First**. Together with the other LHINs, Central LHIN will have a critical role in advancing the four objectives in the plan:

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

There are a number of key projects underway within the Central LHIN that will bridge our local system to the next phase of transformation. These bold new initiatives will create capacity in home and community care, with a continued and sharpened focus on the patient and caregiver experience. These projects are conducted in collaboration with other LHINs so that patients can access care across LHIN boundaries where and when needed.

Target Audiences

Internal

- Central LHIN Board of Directors
- All employees of Central LHIN
- Physician Leads of Central LHIN

External

Primary

- Patients and caregivers
- Ministry of Health and Long-Term Care
- Members of Provincial Parliament (MPPs)
- Health Service Providers (HSPs) funded by the Central LHIN, including Boards of Directors; staff, physicians and volunteers
- Non-funded partners
- Primary care physicians and nurse practitioners

Secondary

- Mayors and Municipal Councilors
- Members of Central LHIN Committees/Work Groups
- Media
- Other LHINs
- Associations representing health care interests – i.e. Ontario Hospital Association; Ontario Long-Term Care Association, Association of Family Health Teams of Ontario, Ontario Medical Association, Nurse Practitioners' Association of Ontario, etc.

Key Messages (Provincial)

- Putting people and patients first by improving the health care experience.
- Providing information to make decisions, and tools to live healthy and stay healthy.
- Providing better access to quality health services, and protecting those services for generations to come.
- Patients First:
 - a caring, integrated experience for patients
 - faster access to quality health services
 - for all Ontarians at every life stage
- Access:
 - Providing faster access to the right care
- Connect:
 - Providing better home and community care
- Inform:
 - Providing information to make the right decisions about your health
- Protect:
 - Ensuring our universal health care system is sustainable for generations to come

Key Messages (Local)

- Together with our partners, Central LHIN is building a strong, seamless and sustainable local health care system for the residents who live today in our region – and for future generations.
- The voice of the patient and caregiver give us a unique lens to shape the future of care, findings and results of engagement will be integrated into our planning, including our transformational projects.
- By believing that **“Together, we’re better!”** our Health Service Providers and non-funded partners are working with us to create plans that will build a bridge to the next phase of transformation.
- Central LHIN plays a key role in advancing the Ontario health care agenda by putting patients first, increasing access, improving quality, and providing better home and community care.

Communication Strategies

1. Develop, implement and evaluate communication plans to support each of the key transformation projects underway within the Central LHIN. Outline core deliverables in each plan to help facilitate understanding of each project among key stakeholders and move implementation forward successfully.

2. Position the Central LHIN as a key player within the transformation of Ontario's health system and as the lead in health system transformation within our region. Use a variety of communication tools and tactics to showcase and celebrate shared accomplishments, and to highlight the implications and improvements in the delivery and integration of system-wide patient care.
3. Integrate the 'voice' of the patient and caregiver into our communications whenever possible – their stories, experiences and ideas for improving the system.
4. Manage and respond to ongoing issues with transparency, responsibility and integrity.
5. Evaluate our current communication tools and tactics to confirm that we are integrating best practices and reaching our key audiences in the way that is most effective for them.

Tactics

To help us achieve our objectives, we will deploy a number of communication tactics, including but not limited to:

- Website content
- LHINfo Minutes
- Media materials and events, including those hosted by our MPPs
- Our CEO blog/column – LH/N Touch
- Distribution of targeted communications to our HSPs
- E-newsletter for our HSPs and other partners
- Community Report
- Videos, posted on our website
- Brochures and flyers

Evaluation

The success of our communications initiatives will be evaluated in these ways:

- Website analytics
- Uptake of key messages in local media
- Internal communication survey
- Regular communication consultation with our Citizens Health Advisory Panel (CHAP)
- Feedback during MPP visits and Municipal Breakfasts
- Questions and comments received in the Central LHIN mailbox account

4.5 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 achieve the right level of community engagement to support our projects and planning activities outlined in our Annual Business Plan for 2015-16.

Engagement Strategies

Central LHIN supports the concept of a continuum of engagement strategies. Our engagement strategies will fall within this framework, with strategies chosen to 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 experiences and insights from stakeholders on matters that directly affect them or where they have a significant interest. Envision 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 at the system-wide level to facilitate understanding of issues and concerns. Supports collaboration between the LHIN and stakeholders or between groups of stakeholders. Engagement will contribute to 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

- **Residents of Central LHIN** as consumers of health care services and supports
- **Primary care providers** (physicians, nurse practitioner led clinics, community health centres, 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**

- **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 2015-16 are as follows:

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 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 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 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 bi-monthly 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. Central LHIN formed a Local Partnership in April 2014, 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 LHIN Hospice Palliative Care Advisory Committee – The Central LHIN is in the process of establishing a Central Hospice Palliative Care Advisory Committee to advise the 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 Information Technology 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.

The York Region Mental Health Supports within Housing Strategy Steering Group supports the development and implementation of this key strategic initiative within Central LHIN. The Steering Group is comprised of members from York Region, the Ministry of Health and Long-Term Care, and Central LHIN. Consumers are involved throughout the planning process.

Regional Chronic Disease Prevention and Management Committees – The 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.

2015-16 Engagement Activities

- Annual Business Plan 2016-2017 Collaborative Planning Sessions
- Integrated Health Services Plan 2016-2019 Collaborative Planning Sessions
- Comprehensive and effective engagement with Health Service Providers and stakeholders including engagement of caregivers and clients to understand care needs, gaps and future opportunities
- Health Links Engagement
- Mental Health and Addictions engagement
- Hospice Palliative Care Forums and Engagement
- Family Health Team Engagement and Nurse Practitioner Led Clinics in Quality Improvement Plan reviews with hospitals, CCAC, Long-Term Care Homes and Community Health Centres
- Aboriginal Community Engagement
- Entité 4 /Central LHIN Engagement with Association of York Region Francophones
- Francophone Community Engagement

Engagement of Specific Populations

Engagement of the Francophone Community: Central LHIN has approximately 1.9% 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 reports, 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 2014/15. 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: seniors' 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. 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 informed the need for cultural competency training for LHIN staff and health service providers. This training was provided in 2014-15 and will be ongoing.

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