Central **LHIN** | **RLISS** du Centre

Annual Business Plan

2016-2017

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

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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 in 2006 by the Ontario government to plan, coordinate, integrate and fund health services at the local level. LHINs are organized around geographic regions to facilitate system-wide planning, with consideration of local needs. Geography is not a barrier to service, and patients may move freely between LHINs to receive health care services.

Central LHIN's fourth Integrated Health Service Plan (IHSP) 2016-2019 is the roadmap to move us toward achieving our vision of *Caring Communities, Healthier People*. Our vision inspires the Central LHIN to work with patients, families, Health Service Providers (HSPs), non-funded partners such as municipalities, and the Ministry of Health and Long-Term Care and other Ministries to build a strong, sustainable system that will be here to serve and support future generations.

In the development of the Annual Business Plan (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.

Six key strategic priorities were articulated in the IHSP 2016-2019. The priorities reflect provincial directions for the Ontario health care system, as well as local feedback on how best to strengthen our capacity and commitment into the future. **'Together, we're *better!'***

Our Strategic Priorities

The Central LHIN 2016-2017 Annual Business Plan (ABP) outlines the implementation of the first year of initiatives to deliver on our three-year IHSP. The Plan highlights new and continuing strategic initiatives to deliver on results within the provincial and local context and aligns with Ontario's ***Patients First: Action Plan for Health Care, 2015***.

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

The Central Local Health Integration Network (LHIN) funds 96 Health Service Providers approximately $1.9 billion through 109 Service Accountability Agreements. The number of providers funded in each sector is as follows:

- Seven public* and two private hospitals
- 46 Long-Term Care Homes
- One Community Care Access Centre (CCAC) – the Central CCAC
- 36 Community Support Service (CSS) providers
- 23 mental health and addictions service providers
- Two Community Health Centres (CHCs)

  *(Source: March detailed 2015 MLPA funding documents. *7 public hospitals includes West Park Health Centre (Ventilator Beds))*

A full list of our Health Service Providers can be referenced on our website at www.centrallhin.on.ca

Moving forward, the following key initiatives will significantly advance the six strategic priorities of the IHSP 2016-2019, *Caring Communities, Healthier People*.

Better Seniors Care

- Complete a Long-Term Care capacity assessment to develop and implement alternatives to institutionalized care for seniors.
- Develop and implement focused and sustainable improvement strategies to enhance system capacity across the continuum to address Alternate Level of Care (ALC) patients in Central LHIN hospitals.
- Continue to implement, evaluate and spread assess/restore pilot projects to enhance rehabilitative and restorative care services to prevent functional decline for frail elderly patients.
- Align Specialized Geriatric Services to Long-Term Care Homes with the LHIN planning areas
- Develop and begin implementing a phasing and risk management plan for the Ministry 10-year Long-Term Care Home redevelopment initiative in the Central LHIN for the 21 Long-Term Care Homes identified for redevelopment, including capacity planning, licensing and decanting.

Better Palliative Care

- Continue to strengthen capacity of specialists and generalists through education and standardization of tools.
- Implement palliative care medical services to provide a common basket of services and supports in alignment with the LHIN planning areas.
- Implement the plan to increase palliative care capacity in Long-Term Care Homes through education and supports.
- Implement one new residential hospice.

Better Care for Kids and Youth

- Initiatives are planned for fiscal 2017-18 forward.

Better Community Care

- Implement the Home and Community-based Care Coordination and the Personal Support Services (PSS) Policy Guidelines to coordinate and optimize home and community care for older adults.
- Engage primary care to develop an integrated model and implementation plan for primary care service delivery that aligns with the Central LHIN planning areas.
- Continue to create closer linkages between Central LHIN and the three Public Health Units to enhance planning in the Central LHIN planning areas.

Better Care for Underserved Communities

- Complete development of the North York West multi-year action plan and implement early initiatives.
- Develop and implement a regional model for delivery of Chronic Disease Prevention and Management programs that leverages the Diabetes Education Programs delivery model and aligns with primary care.
- Improve access to services for the Aboriginal population in Central LHIN, including Georgina Island.
- In collaboration with Entité 4, CE LHIN and TC LHIN, leverage current resources to establish and implement the Mental Health and Addictions access pathway for Francophone services and leverage the Francophone navigator work to increase access to primary care services in French in the North York West area

Better Mental Health

- Evaluate the mobile crisis co-responder models to determine best practice and implement standardized model; evaluate impact of key initiatives of the Mental Health and Addictions Action Plan and Coordination Council for York Region.
- Continue to expand access to supportive housing.

Additional LHIN Operational Activities that Support Achieving Our Mandate

Capital Redevelopment Planning

In November 2010, the Ministry of Health and Long-Term Care and all Ontario LHINs released a Joint Review Framework for early capital planning. Under this framework, the LHIN plays a critical role in advising the Ministry, and endorsing the program and service elements of all capital projects in the early capital planning stages. The LHIN works with its Health Service Providers to identify and prioritize local health service needs and to determine the associated capital needs.

Central LHIN hospitals are at various stages of capital planning. The Central LHIN will continue to work with its hospitals to:

- Support the implementation of the Post Construction Operating Plan at the Wilson site and capital planning for the Humber River Hospital's Finch and Keele site.
- Support the implementation of the Post Construction Operating Plan at Markham Stouffville Hospital.

- Support capital planning for the redevelopment of Stevenson Memorial Hospital.
- Support capital planning and redevelopment of cardiac and Magnetic Resonance Imaging (MRI) programs at the Southlake Regional Health Center.
- Support various initiatives at North York General Hospital including redevelopment of the Phillips House for mental health programs, completion of the fit-up of the 7th and 8th floor inpatient units, and redevelopment of the Emergency Department.

Performance Management

Central LHIN is responsible for the development and establishment of local health care system funding plans and performance targets for health service providers in the Central LHIN. This entails working with over 100 health service providers across multiple sectors to implement accountability agreements. Health service provider performance against accountability agreement targets is monitored and managed using a risk based approach. The LHIN provides advice and support to resolve issues and works with health service providers to optimize performance. Performance management is foundational to achieving the Central LHIN vision.

Program Monitoring

In addition to health service provider performance management, the LHIN has implemented a program monitoring function to monitor significant investments at a program level. This supports the provincial priority of protecting our universal public health care system by:

- Driving system quality improvement and supporting health service providers to be successful in new program implementation
- Obtaining value for money for the health system
- Informing future planning activities

Health service providers are required to report program performance against targets for the following categories:

1. *Ministry LHIN Accountability Agreement indicator– to align with provincial targets*
2. *Client satisfaction – to align with the Patient's First Action Plan*
3. *Access & connect – to align with the Patient's First Action Plan*
4. *Program mandate – to ensure that the program is achieving the intended program objectives*

Central LHIN monitors an average of 10-15 new programs at any one time.

4.1.3 Environmental Scan of Opportunities and Risks

Population	**1.9M**	Central LHIN's 2015 population represents 14 per cent of the entire province – the largest number of Ontarians living in any LHIN.
Population Growth	**17.1%**	Projected growth rate forecasted from 2015 to 2025.

Immigration		**48.6%**	Almost half of our residents were not born in Canada (highest in Ontario).
Seniors	**2015**	**14.3%**	268,750 Central LHIN residents are aged 65+, the highest in the province.
	2035 (projected)	**23%**	By 2035, Central LHIN is projected to have over half a million seniors (570,487) residing within its boundaries making up 23 per cent of the population.
Children (0-4 years)		**5.6%**	Central LHIN has the highest proportion of children of any LHIN. Central LHIN also has the second highest number of births (~18,000) of all LHIN regions.
Language		**4.9%**	The percentage of Central LHIN residents with no knowledge of English or French.
Francophone		**1.3%**	The percentage of our population who are Francophone.
Aboriginal		**0.5%**	The percentage of our residents who are Aboriginal, with the majority of these living in urban centres.

Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015; 2011 Census-based Ministry of Finance Population Estimates (2011-2013) and Projections (2014-2041) for Local Health Integration Networks, Ministry of Finance; Better Outcomes Registry & Network (BORN) Ontario, 2011/12

Central LHIN is comprised of a unique urban/rural geography encompassing the northern section of Toronto, all of York Region and the southern part of Simcoe County. Central LHIN's population is projected to grow at a rate of 17.1 per cent between the years 2015-2025, making Central LHIN one of the fastest-growing LHINs in the province. A rapidly growing population brings increased care needs for our residents.

Key Issues and evolving drivers impacting the health system within the Central LHIN include:

A growing senior population and increased complexity in the community

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 and those 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 the sustainability of a coordinated, integrated and efficient health system, regular access to preventative care, primary care, community health services, mental health and substance abuse services, palliative services, Long-Term Care and self-management support is imperative. New and emerging initiatives such as a Seniors Action Plan, Health Links, focused mental health and substance abuse planning, implementation of a regional hospice palliative care plan, realignment of community chronic disease programs and integrated regional planning initiatives are underway to provide a system of collaborative care for our planning areas , with a focus on seniors and complex patients. In addition, a number of capital infrastructure initiatives are underway to address the strain a growing population has had on our hospitals.

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

Central LHIN encompasses a mix of rural and urban communities with 14 per cent of residents living in rural communities and 86 per cent living in large urban centres *(2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015)*. 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 continued expansion of the telehomecare and telemedicine programs, focused planning with the municipalities and Primary Care in the planning regions, and collaboration with the Ministry and Health Force Ontario to meet local health human resource needs, especially in the rural areas, will result in improvements to access to services.

Addressing health care needs of diverse and at-risk communities and populations

The Central LHIN is a diverse community with the highest proportion (49 per cent) of immigrants in the province. Central LHIN is home to a small population (0.5 per cent) of Aboriginal people, and approximately 1.3 per cent of the population is Francophone. (*Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015).* These characteristics contribute great depth and richness to our society, and respecting and integrating culturally appropriate solutions into our health care strategies is an important priority for Central LHIN.

The low supply of affordable housing and the percentage of people living in low income households is a growing area of concern. The provincial rate of people living in these households is 13.9 per cent compared to the Central LHIN average of 14.5 per cent. In addition, certain LHIN planning areas have greater socioeconomic challenges and higher rates of chronic diseases than others.

Health system planning for Central LHIN residents within the local planning areas will promote holistic and culturally-adaptive strategies for all, taking into consideration local population contexts to better meet the care needs of diverse and at-risk populations. By embedding these strategies into our planning, leveraging partnerships with municipalities, cross-sector stakeholders, and Entité 4 and continuing to engage with our diverse communities, the needs of our residents will drive system change and guide directions for health system planning.

Patient Acuity

Central LHIN emergency departments see a large proportion of high acuity patients. In 2014-15, Central LHIN ranked as the third highest LHIN in the province for the number of emergency department visits that were of higher acuity on the Canadian Triage Acuity Scale (CTAS) *(Source: ER_Pay for Results Year 7 Fiscal Year Report, March 2015)*. This is an indication of the ongoing increases in demand placed on Central LHIN health service providers. Additionally, there is an increasing percentage of Central Community Care Access Centres (CCAC) long stay clients that are high/very high needs: 58 per cent in 2012-13 vs 75 per cent in 2015-16. (Source: Central CCAC Key Trends Analyses)

High birth rate and proportion of children with medical complexity

Central LHIN has the second highest 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: Provincial Council of Maternal and Child Health: Health Care Symposium Report, ICES, January 2012)*

4.2 Core Content – Template A

Better Seniors' Care

Integrated Health Services Priority

IHSP Priority Description

Develop specialized strategies and support systems to help older adults stay healthy and independent at home for as long as possible. Reduce reliance on acute care by exploring and implementing other options that are senior-friendly and cost-effective.

Current Status

Scope of Services, Providers and Clients Served:

- In 2015, there were approximately 268,750 seniors over the age of 65 living within Central LHIN's boundaries, representing 14.3 per cent of the LHIN's total population. This is the highest absolute number of seniors (65+) among all of the LHINs. (*2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015*)
- The Central LHIN funds 46 Long-Term Care Homes (LTCH) encompassing approximately 7000 beds. Additional services are provided by specialized geriatric teams such as the psychogeriatric outreach teams, behavioural support teams, nurse-led outreach teams, geriatric mental health outreach teams, palliative care clinical nurse consultants, LTCH nurse practitioners, and in home-services (rehab/nursing) provided by the CCAC. In 2015-16 Q1/Q2, the CCAC provided care to 369 LTCH residents *(Source: CHRIS, Central CCAC).*
- In order to increase the capacity of Long-Term Care Homes, Central LHIN has funded 84 interim beds, including a 20 bed renal unit, from discretionary funds. The LHIN has 70 convalescent beds, 39 of which are funded from LHIN discretionary funds.
- Central LHIN funds 205 Home First spots through the Central Community Care Access Centre. In fiscal year 2014-15, 1,465 clients received care and services through the Home First program

(Source Central CCAC 2014-15 Annual Report). Of this number, over 70% of the discharged clients from the Home First program remained in the community on regular CCAC service for an average of 1.66 years before being discharged from the program. Previously, many of these clients would have been discharged from the hospital directly to a Long-Term Care Home.

- Emergency departments (ED) in Central LHIN have specialized services to meet the unique needs of frail seniors when they arrive in the ED. Geriatric Emergency Management (GEM) nurses, currently located in five of Central LHIN's hospitals, are trained to provide care for the specific medical and social needs of complex frail seniors such as falls, delirium, dementia, depression, elder abuse, pressure ulcers, incontinence, malnutrition and functional decline *(Source: RGPs of Ontario, 2013).*
- Central LHIN funds ten Community Support Service (CSS) providers to deliver assisted living under the Assisted Living for High Risk Seniors Policy to provide services for over 1,400 seniors who can reside at home in the community and require the availability of scheduled and unscheduled personal support and homemaking services on a 24-hour basis. The LHIN also funds six providers to deliver assisted living services under the Assisted Living Services in Supportive Housing Policy, 1994, for persons with physical disabilities and acquired brain injuries, as well as attendant outreach services.
- Two Integrated Funding Model Pilot Projects are underway. They provide the following services to seniors:
    - *One Client, One Team: Central and Toronto Central LHIN Integrated Stroke Care* is comprised of hospital and community partnerships that span across two LHINs. The pilot is intended to improve the efficiency and effectiveness of care for patients recovering from stroke with the implementation of a seamless patient centered integrated stroke care pathway from hospital to home.
    - *Integrating Specialized and Primary Care: The North York Central Collaborative for COPD and CHF Patients*, includes hospital and community partners in Central LHIN. The objective of this care model is to provide integrated care for patients with mid- to end-stage Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) as they transition from hospital to home for up to eighteen weeks post-discharge. The approach will include dedicated care coordinators, a 24/7 access line for patients, remote consults enabled through technology and specialist follow-up including ambulatory rehabilitation.

Key Issues:

- Increasing prevalence of seniors with complex medical conditions in the community.
- 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 in the community to care for seniors with complex conditions resulting in more Alternative Level of Care (ALC) days in hospital (e.g. the frail elderly with behavioral conditions such as dementia) and caregiver burnout in the community.
- The average occupancy of Central LHIN LTCHs has been consistently high, reaching levels of 99 per cent or greater. Central LHIN also has one of the lowest bed supply to senior ratios in Ontario for those 75 years of age or older, resulting in limited access to LTCH services in a timely manner.
- The Ministry led Enhanced LTCH Renewal Strategy requires older homes that do not meet current design standards to redevelop over the next ten years. Twenty-one Central LHIN homes are eligible for redevelopment. This may result in the temporary closure of LTC beds while homes renovate or rebuild in a new location or a loss of permanent LTC bed capacity due to homes

downsizing in order to meet current design standards that require larger resident living space or the potential relocation of beds if providers choose to rebuild outside of Central LHIN due to high land costs in the GTA.

Successes:

- In 2015-16, Central LHIN expanded the assisted living program by funding services for an additional 110 high risk seniors. As a result, this expansion reduced the CCAC waitlist for personal support services and enabled more seniors to live independently at home.
- In partnership with stakeholders in the Hospitals, Central CCAC and Central LHIN, four Home First projects were developed and piloted in 2015 and fully implemented in fiscal 2016. These projects focused on:
    - Reducing social admissions from the emergency department (ED);
    - Establishing a Home First Fast Track Process;
    - Home First family meeting improvement, and;
    - Establishing Home First Communication Standards and Guidelines.
- All 46 Central LHIN Long-Term Care Homes are equipped with two-way videoconferencing equipment for clinical consults so that residents are able to receive more care in their home.
- Central LHIN expanded its Telehomecare program across the LHIN.
- 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).
- Markham Stouffville Hospital and Southlake Regional Health Centre have committed to establishing Stroke Care Units in compliance with the provincial Stroke Unit definition under Quality Based Procedures (QBP), thereby enhancing high quality, regional stroke care for Central LHIN patients.
- Assess and Restore is a three-year pilot project that was implemented within Central LHIN in 2014-15 for the purpose of supporting the delivery of targeted and timely clinical interventions to frail seniors to prevent deconditioning, and to build strength, mobility and functional ability. In 2015-16 the Assess and Restore program was broadened to include a custom in-home rehabilitation program through the CCAC and assignment of a dedicated care coordinator for patients admitted to the program. Assess and Restore is being piloted at North York General Hospital to include a seven days/week, standardized rehabilitation program, as well as the launch of a custom outpatient pilot program to provide short-term, exercise-based conditioning for patients not eligible for home-based rehabilitation services and/or patients that have completed the in-home program.

Goals

Goal 1: Seniors will have better and timelier access to care in the community to help them live safely and independently at home.

Goal 2: Seniors will have better outcomes and will be less likely to decompensate in hospital.

Goal 3: Seniors with dementia or behavioural issues will receive timely access to appropriate care.

Goal 4: The number and types of Long-Term Care beds will align to what the community needs.

Consistency with Government Priorities

The goals support the Ministry's priorities by ensuring that seniors have timely access to high quality care that is equitable, promotes patient choice, and provides good value for money. By strengthening home and

community care through improved client and caregiver experience, greater quality, consistency and transparency, modernized delivery systems and investments focused on increasing capacity in the community, Ontario's seniors will have access to the right care, at the right time, in the right place.

Action Plans/Interventions

Action Plans	2016-17		2017-18		2018-19	
	Status	%	Status	%	Status	%
Complete a LTC capacity assessment to develop and implement alternatives to institutionalized care for Seniors	In progress	50	Completed	50		
Develop and implement focused and sustainable improvement strategies to enhance system capacity across the continuum to address Alternate Level of Care (ALC) patients in Central LHIN hospitals	In progress	50	Completed	50		
Continue to implement, evaluate and spread assess/restore pilot projects to enhance rehabilitative and restorative care services to prevent functional decline for frail elderly patients	Completed	100				
Align Specialized Geriatric Services to Long-Term Care Homes with the LHIN planning areas	Completed	100				
Develop and begin implementing a phasing and risk management plan for the Ministry 10-year LTCH redevelopment initiative in the Central LHIN for the 21 LTCHs identified for redevelopment, including capacity planning, licensing and decanting	In progress	10	In progress	15	In progress	15

How will we measure success?

- Achievement of Ministry-LHIN Accountability Agreement (MLAA) indicators for Alternate Level of Care (ALC) rate (LHIN MLAA target: 12.7 per cent) by end of the 2016/17; and percentage of ALC days (LHIN MLAA target: 9.46 per cent) by end of the 2017/18.
- Readmissions within 30 days for selected chronic conditions will decrease (LHIN MLAA target: 15.5 per cent).

What are the risks/barriers to successful implementation?

- Resistance among health service providers regarding a service re-design of specialized geriatric services.

- Sustainability of the Assess and Restore projects when the funding stops at the end of the pilot period.

For each risk/barrier, describe the plan to mitigate the risk

- Develop a Community Engagement Plan early on so Health Service Providers can contribute to the creation of the future state of specialized geriatric services.
- The hospital (North York General Hospital) and CCAC will work to realize any cost efficiencies for the sustainability of the Assess and Restore projects.

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

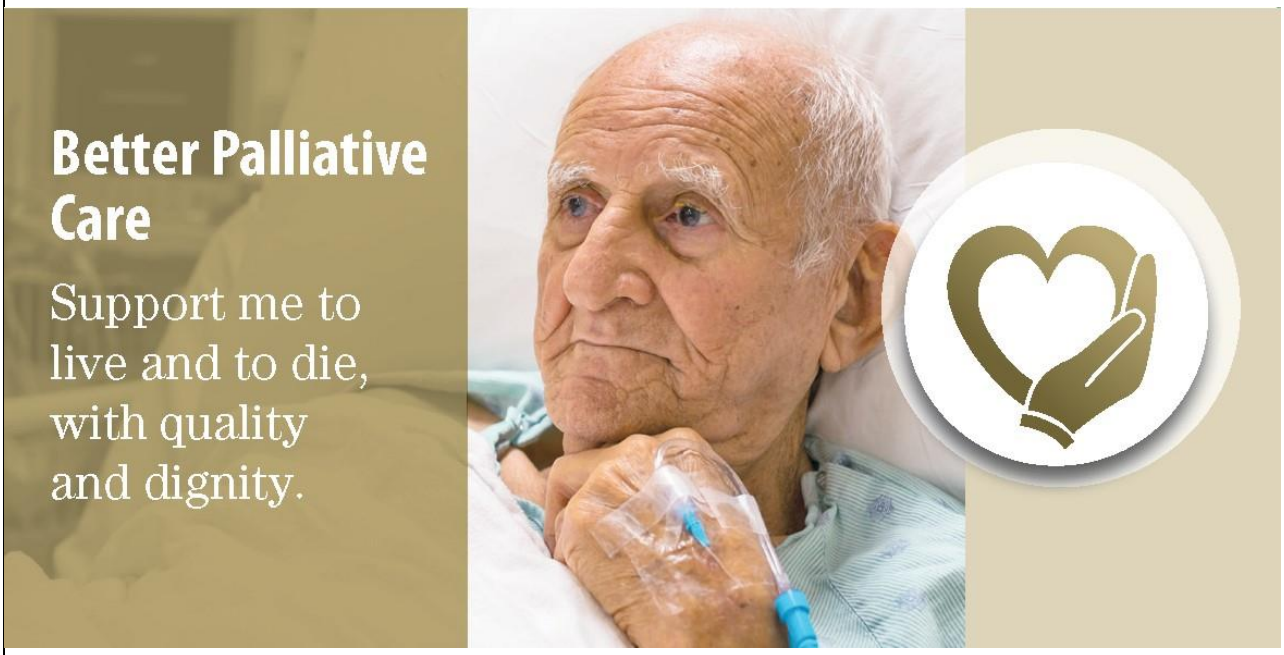
- Continued collaboration and engagement with primary care providers, health service providers, LHIN partners and other key stakeholders, including those who use the health care system.
- Continued alignment of Assess and Restore programs and initiatives to the Ministry guidelines.
- Leverage remote monitoring technology in congregate settings like LTCHs and Assisted Living to improve access to care, keep patients in their homes, and prevent hospital visit(s) where appropriate.

Additional Comments

- ALC rate is a new indicator to measure ALC performance, as defined by the MLAA. Therefore, previous targets had not been established for this indicator. As noted earlier, the goal in Central LHIN is to achieve an ALC rate of 12.7 per cent by the end of the 2016-17.

Better Palliative Care

Integrated Health Services Priority



IHSP Priority Description

Provide holistic, proactive and continuous care and support for patients with progressive, life-limiting illness and for their families. Support families through the entire spectrum of care before and after death by helping patients to live as they choose, and to die in their preferred location of choice – with quality of life, comfort, dignity and security.

Current Status

Scope of Services, Providers and Clients Served:

- 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 consultation on palliative pain and symptom management services. In 2014-15 the Hospice Palliative Care teams received 1,406 referrals.
- Besides the Hospice Palliative Care Team at Southlake, Central funds five other Community Support Service providers for visiting hospice and palliative education services.
- 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 is working towards securing a site to build a 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 in 2017.
- Central CCAC provides palliative care support for clients across Central LHIN at home and in residential hospices. In 2014-15, 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 co-ordination. Of the $26 million, Central CCAC was funded for over $13 million to provide over 228,000 hours of in-home end-of-life care. Over 600 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 CHRIS Central CCAC, December 2015)

- Central LHIN hospitals treat over 3000 palliative patients a year in an acute setting and also care for palliative patients in complex continuing care units. (Source: intelliHealth DAD discharges ICDA-CA code Z51.5 and MoHLTC HSIMI tool, multiple years)

Key Issues:

- It has been estimated that only 16-30 per cent of Canadians have some level of access to palliative care and support appropriate to their needs, and the majority of individuals that do have access often have a diagnosis of cancer. (Source: Advancing High Quality, High Value Palliative Care in Ontario Declaration of Partnership, 2011)
- In Central LHIN, 60 per cent of deaths are from chronic progressive diseases. (Source: Final Recommendations for an Integrated, Patient Centred Regional Hospice Palliative Care system in the Central Region, 2014)
- 25 per cent of Long-Term Care Home residents died in an emergency department or an acute care bed. (Source: Final Recommendations for an Integrated, Patient Centred Regional Hospice Palliative Care system in the Central Region, 2014)
- 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)
- 66 per cent of patients say they would prefer to die at home – but the reality is that only 22 per cent of Central LHIN deaths take place at home, giving us significant room for improvement. Within the Central LHIN in 2012-13, 47 per cent of deaths took place in acute care hospitals; and 28 per cent occurred in the emergency department or in complex continuing care and rehabilitation facilities. About 13 per cent took place in Long-Term Care Homes – which is considered by many residents to be 'home.' (Source: Palliative Care in Ontario, February 2014 Updates, Health Analytics Branch).

Successes:

- Central LHIN established a patient registry and centralized access to residential hospice beds. Centralized and coordinated access to palliative care services for patients and families is now available by calling one telephone number at the Central CCAC.
- An online directory of palliative care and end-of-life resources is now available on the CCAC website at www.centralhealthline.ca.
- To provide urgent palliative support during the last stages of life, the Central LHIN led the development, and managed the launch of a single telephone number for crisis palliative care situations. The central telephone number – 1-844-HERE4ME – is managed by SYKES Assistance Services Corporation, also the provider of Telehealth Ontario. The calls are triaged through Registered Nurses, and provide patients with an integrated level of support that had not been available in Ontario in the past. Expertise is provided to manage emotional or physical changes, worsening or changing physical pain or symptoms and to cope with medical equipment and supply concerns.
- The Central LHIN funded the Hospice Palliative Care Team at Southlake Regional Health Centre to establish a standardized education program across Central LHIN for all palliative care providers, volunteers and families/caregivers that is based on best practice.
- An implementation plan was developed for specialist support to primary care practitioners for pain and symptom management, medical management and interventions, care coordination and navigation with linkages to education, hospice services, and grief and bereavement services through a single point of access.
- Central LHIN also began the development of a plan to enhance capacity in Long-Term Care Homes through education and training.

- The Central LHIN established the Palliative Care Coordination Council in alignment with the recommendations of the Ontario Palliative Care Network. The Council will provide guidance to the implementation of the Central LHIN Action Plan and identified provincial initiatives.

Goals

Goal 1: Patients have the choice to live their end-of-life period in their preferred location.

Goal 2: Improved community access to essential supports and services, including advanced care planning.

Goal 3: Easier navigation system for patients and caregivers.

Goal 4: Palliative residents in Long-Term Care Homes will benefit from care providers with enhanced knowledge and skills to support them.

Goal 5: Specialist will provide support and education to primary care providers to support their patients through their end-of-life journey.

Consistency with Government Priorities

The goals support the Ministry's priority of delivering better, coordinated and integrated care in the community, closer to home, including enhancing palliative care at home or out-of- hospital.

Action Plans/Interventions

Action Plans	**2016-17**		**2017-18**		**2018-19**	
	Status	%	Status	%	Status	%
Continue to strengthen capacity of specialists and generalists through education and standardization of tools	In progress	50	Completed	50		
Implement palliative care medical services to provide a common basket of services and supports in alignment with the LHIN planning areas	Completed	100				
Implement the plan to increase palliative care capacity in Long-Term Care Homes through education and supports	In progress	50	Completed	50		
Implement one new residential hospice	In progress	10	Completed	90		

How will we measure success?

- Percentage of palliative days in acute care as a per cent of total patient days in acute care will decrease.
- Percentage of palliative care patients discharged from hospital with home support will increase.

What are the risks/barriers to successful implementation?

- Change management regarding the acceptance of new models of care recommended as a result of the Palliative Care Action Plan.

For each risk/barrier, describe the plan to mitigate the risk?

- Continued comprehensive and effective engagement of Health Service Providers, stakeholders, Primary Care and the public. Utilize the Central LHIN Citizens Health Advisory Council as needed.

- Continue to leverage the perspective of families/caregivers on the Palliative Care Coordination Council to maintain the focus on the patient.

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

- Broaden use of technology to support provision of care in the home-setting, and the delivery of training to enhance skills of providers of palliative care. Expand use of remote monitoring technology, and two-way videoconferencing between Hospice Palliative Care teams, Clinical Nurse Consultants, and Long-Term Care Homes.
- Leverage provincial electronic tools such as the Health Link's Care Coordination Tool to improve care coordination and communication between members of the circle of care.

Additional Comments

- The new Palliative Care Coordination Council, established in early 2016, is guided by and aligned with the emerging Ontario Palliative Care Network (OPCN) as well as The Clinical Council of the Hospice Palliative Care Provincial Steering Committee's draft Essential Minimum Clinical Standards for Hospice Palliative Care in Ontario (January 2015).

Better Care for Kids and Youth

Integrated Health Services Priorityl

IHSP Priority Description

Develop new partnerships and innovative models to bring specialized care closer to home, for children and youth.

Current Status

Scope of Services, Providers and Clients Served:

- Central LHIN funds an innovative congregate care model which is a partnership with the March of Dimes, Central CCAC, and the Reena Residence in Vaughan, to address the needs of young adults with complex medical needs. Seven individuals are served under this model.
- In 2014-15, the Central LHIN funded a new congregate care model which is a partnership with the Ministry of Community and Social Services, the March of Dimes and Central CCAC to address the needs of young adults with complex medical and developmental needs who could not direct their own care. Nine individuals are served under this model.

Key Issues:

- The Central LHIN will experience an increase of 15.47 per cent of paediatric population from 2006 to 2021.
- Paediatric care is unique in its nature and requires different planning considerations, care partnerships and investments. A number of trends in treatment and care have led to the centralization of paediatric admissions across a small number of specialized Children's Hospitals. However, hyper-concentration creates challenges of convenience and access.
- Central LHIN paediatric residents are travelling outside of the LHIN for emergency care: approximately 17 per cent of emergency department visits made by Central LHIN children are to hospitals in Toronto Central LHIN, primarily Sick Kids. (Source: IntelliHealth NACRS, 2012/13 & 2013/14)
- Youth and young adults with medical complexities, who are unable to manage their own care, often have extensive family caregiver's support. In situations where parents are aging, viable options may

be limited to Long-Term Care Homes or hospitalization. (Source: Cross LHIN Transitional Aged Youth and Young Adult with Medical Complexity Initiative Cross Sectoral Congregate Care Model Building the Transitions towards Care, Inclusion and Participation, March 31, 2014)

- In 2015, eight young adults were living in Long-Term-Care Homes. (Source: CCAC)
- Based on the analysis of December 2013 CCAC data, the cross-sector GTA LHIN report, Building the Transitions towards Care, Inclusion and Participation, identified Central LHIN as having the highest number of individuals with medical complexity across the province. (Source: Cross LHIN Transitional Aged Youth and Young Adult with Medical Complexity Initiative Cross Sectoral Congregate Care Model Building the Transitions towards Care, Inclusion and Participation, March 31, 2014)

Successes:

- In 2014-15, the Central LHIN established a partnership with the Ministry of Community and Social Services (MCSS) to leverage previous work and develop a model focused on young adults with both developmental and medical complexity who could not direct their own care. The model became fully operational in 2015-16.

Goals

Goal 1: Improved access to hospital paediatric care.

Consistency with Government Priorities

The goals support the Ministry's priority of providing faster access to the right care, including more coordinated care for patients with complex medical conditions.

Action Plans/Interventions

Action Plans	2016-17		2017-18		2018-19	
	Status	%	Status	%	Status	%
Complete a current state analysis to identify gaps	Deferred		Completed	100		
Implement best practices and enhance standardization for acute paediatric care in all hospitals across the Central LHIN	Deferred		In progress	50	Completed	50

How will we measure success?

- Outflow of Central LHIN paediatric residents to other LHINs for paediatric care will decrease.

What are the risks/barriers to successful implementation?

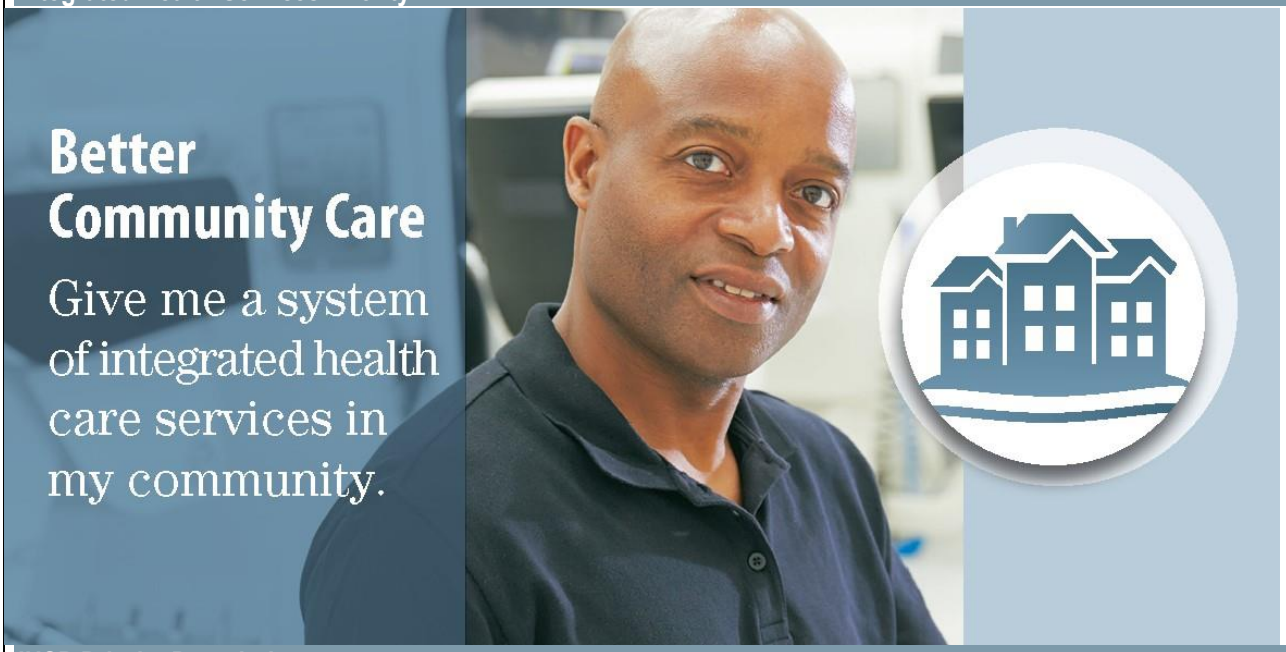
- Multiple change initiatives are underway which may stretch the capacity of health service providers to implement and sustain new initiatives.

What is the plan to mitigate risk?

- Engage all relevant stakeholders, early and throughout the change design and implementation process.

Better Community Care

Integrated Health Services Priority



IHSP Priority Description

Create stronger links to integrated community services and to primary care, to help patients recover and receive more of their health care at home, with safety and independence.

Current Status

Scope of Services, Providers and Clients Served:

- Central LHIN has one CCAC, two Community Health Centres (CHCs) and 36 Community Support Service (CSS) providers. These agencies provide support services to assist with independent living in the home or in supportive residential settings, including homemaking, dining and meal services, security checks, transportation services, respite care and palliative care services.
- Highlights of services provided include:
    - 43 adult day programs and 613 exercise/falls prevention classes. (Source: Central LHIN internal data)
    - In 2014-15, 2,616 people received assisted living services, 21,824 people received CCAC personal support services and 5,014 people had 291,727 meals delivered to them. (Source: MOH Health Care Indicator Tool)
    - Central LHIN provides LHIN supported transportation to medical appointments and other LHIN funded programs such as adult day programs. In 2014-15, over 250,000 rides were provided to close to 14,500 clients. The LHIN recently implemented a new model for transportation services to increase access and enable a seamless system from a client perspective.
    - Our two CHCs provided services to over 11,500 people, focussing on health promotion, chronic disease management, and providing clinics to a culturally diverse population.
    - Central CCAC provided care and services to 82,587 clients in 2014-15 and supported 36,437 clients on any given day. (Source: Central CCAC 2014-15 Annual Report)

- In 2014-15, 21,053 individuals received nursing visits through CCAC and 14,102 received physiotherapy treatment in their home or school. (MOH Health Care Indicator Tool)

- Central LHIN has 11 family health teams, two nurse practitioner-led clinics, three operational Health Links and two that are in the early stages of implementation.
    - There are approximately 3,007 physicians in the LHIN including primary care and specialists (Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015). Central LHIN funds five community Diabetes Education Programs and two chronic obstructive pulmonary disease (COPD)/chronic heart failure (CHC) clinics.

Key Issues:

- Between 2009 and 2013, the number of Ontario hospital patients discharged with home care services increased by 42 per cent and complexity and duration of home care is also increasing (Bring Care Home Report, 2015). In 2014, 73 per cent of Central Community Care Access Centre (CCAC) clients had high or very high needs compared to 56 per cent in 2009. (Source: Central CCAC Annual Report, 2014/15)
- Between 2010-11 and 2013-14, there was a 30 per cent increase in all home care visits and a 41 per cent increase in service hours. (Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MOHLTC, June 2015)
    - Service types with the largest increase in visits/hours were physiotherapy (189 per cent), speech language therapy (44 per cent), and personal support work & homemaking (42 per cent).
- The system is challenging for clients and families to navigate and services are often fragmented.
- Nine out of ten Ontarians receiving home care services also rely on family caregivers; on average the ratio of professional care giver hours to family caregiver hours is 2:7. (Source: Bringing Care Home Report, 2015)
- The percentage of family caregivers experiencing levels of distress that might prevent them from continuing to provide care to their loved one has more than doubled between 2009 and 2014, from 15.6 per cent to 33.3 per cent. (Source: HQO Annual Measuring Up Report, 2015)
- Family caregivers need more support, including improved options for respite care and flexibility to customize service bundles with available funding to be able to continue their vital caregiving role. They need the system to work for them and with them.
- People with low to moderate care needs are usually able to remain at home or in supportive housing in their community if they receive the right support services. However, clients with lower care needs face increasingly long service waitlists. (Source: Bringing Care Home Report, 2015)

Successes:

- In July 2015, Central LHIN launched its third Health Link in Southwest York Region to provide collaborative care for high needs patients; and the final two Health Links in North York West and Southeast York Region were launched in March 2016.
- Central LHIN funded an expansion of Assisted living for high risk seniors by 110 spaces.
- Central LHIN created a regionalized community transportation model with two lead agencies. iRIDEPlus is an efficient, economical and convenient transportation model that helps seniors across the Central LHIN get safely to medical and other health-related appointments and activities.
- Central LHIN Rapid Response Nurses continue to reduce re-hospitalization and avoidable emergency department visits by improving the quality of transitions from acute care to home care.

In 2014/15, the Rapid Response Nurses completed over 3,000 visits to Central LHIN residents in their homes after hospital discharge.

Goals

Goal 1: Patients and family caregivers will understand what services to expect and be better able to participate in the development of their care plan.

Goal 2: Patient experience across transitions will improve, with standardized assessments and care plans that are shared across providers.

Goal 3: Patients will have more timely access to home and community care, with better outcomes.

Goal 4: Services will be more consistent, efficient, aligned and evidence-based across all providers.

Goal 5: Transparency and ease of navigation will improve for patients and families.

Goal 6: Services will be delivered more efficiently.

Consistency with Government Priorities

The goals support the Ministry's priority to put clients and family caregivers first and to improve their experiences of care by improving quality, coordination and transparency in the home and community care and primary care sectors.

Action Plans/Interventions

Action Plans	**2016-17**		**2017-18**		**2018-19**	
	Status	%	Status	%	Status	%
Implement the Home and Community-based Care Coordination and the PSS Policy Guidelines to coordinate and optimize home and community care for older adults	Completed	100				
Engage primary care to develop an integrated regional model and implementation plan for primary care service delivery that aligns with the planning areas in Central LHIN	In Progress	33	Completed	66		
Continue to create closer linkages between Central LHIN and the three Public Health Units to enhance planning in the Central LHIN planning regions	Completed	100				

How will we measure success?

- Percentage of home care clients with complex needs who received their personal support visit within five days of the date that they were authorized for personal support services will increase. (LHIN MLAA target: 95 per cent)
- Percentage of home care patients who received their nursing visit within five days of the date they were authorized for nursing services will increase. (LHIN MLAA target: 95 per cent)
- 90th percentile wait time from community to the Community Care Access Centre (CCAC) in-home services as measured by time from application from community setting to first CCAC service (excluding case management) will decrease. (LHIN MLAA target: 21 days)
- ALC rate will decrease. (LHIN MLAA target: 12.7 per cent)

- Percentage of alternate level of care (ALC) days will decrease. (LHIN MLAA target: 9.46 per cent)
- Percent of acute care patients who have had a follow-up with a physician within 7 days of discharge will increase. (MLAA monitoring indicator)
- Readmissions within 30 days for selected Health Based Allocation Model Inpatient Group (HIG) conditions will decrease. (LHIN MLAA target: 15.5 per cent)
- Rate of emergency visits for conditions best managed elsewhere per 1,000 population will decrease. (MLAA monitoring indicator)
- Hospitalization rate for ambulatory care sensitive conditions per 100,000 population will decrease. (MLAA monitoring indicator)

What are the risks/barriers to successful implementation?

- Willingness and capacity of multiple stakeholder to engage in significant change in a short period of time.
- Changes must be accomplished within current funding.
- Timeliness and availability of integrated technology infrastructure to support exchange of patient information across providers.

What is the plan to mitigate risk?

- Engage all impacted stakeholders, including clients and families early and throughout the change design and implementation process.
- Explore all opportunities for integration of services to improve efficiency and potentially redirect funding.

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

- Comprehensive and effective engagement with stakeholders.
- Jointly designed implementation plans with clearly outlined goals, timelines and accountabilities.
- Improve the patient experience through the adoption of community clinical data repositories with standardized assessment data (e.g. Integrated Assessment Record, CCAC's Client Health Related Information System) to facilitate sharing of information across providers within a client's circle of care.
- Leverage provincial electronic tools that foster coordinated care including: eNotification of primary care that a patient has been in hospital; eConsult between primary care and specialists; and access to provincial clinical data repositories such as the Integrated Assessment Record and ConnectingOntario.
- Implement 'HSP 360' business intelligence tool across all community agencies for increased transparency and access to information to support discussions between providers in driving performance improvement across the system.

Better Care for Underserved Communities

Integrated Health Services Priority

IHSP Priority Description

Create organized, integrated systems of care to improve early intervention and treatment of disease in neighborhoods or populations (Aboriginal and Francophone) where there are recurring patterns of chronic and acute or episodic health conditions. Develop partnerships that will improve long-term health by addressing the key factors that determine healthy outcomes.

Current Status

Scope of Services, Providers and Clients Served:

- Central LHIN is home to approximately 9,000 Aboriginal people, representing 0.5 per cent of the population (Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015). The Chippewas of Georgina Island, comprised of approximately 200 residents, is Central LHIN's only First Nations and on-reserve community. The majority are living off reserve, primarily in semi-rural and smaller communities in northern York Region and south Simcoe County, and North York West (Statistics Canada, National Household Survey 2011, NHS Profile). Aboriginal people have a greater burden of illness than the general population and that this is exacerbated by barriers to equitable access to health services.
- Addiction Services for York Region is funded to provide Indigenous Cultural Competency Training for Health Service Providers.
- In Central LHIN, 1.3 per cent of the population identified as Francophone, according to the provincial inclusive definition of Francophone (Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015). The majority of the Francophone community is located in North York West and York Region.
- Two hospitals and the Central CCAC have been identified as agencies providing French Language Services (FLS) in Central LHIN.
- Central LHIN community providers have interpretation services available to support non-English speaking residents. In 2014-15, interpretation services were provided to over 1,800 individuals in Central LHIN.

Key Issues:

- Central LHIN's diverse communities each have unique needs and challenges that must be considered when planning.
- 4.9 per cent of Central LHIN residents report having no knowledge of English or French. Research has shown that lower-English proficiency (LEP) patients stay in the hospital between 0.7 and 4.3 days longer than English speaking patients with similar conditions. 24.3 per cent of the patient admissions who did not have an interpreter present either at admission and discharge were readmitted within 30 days, compared to 14.9 per cent with an interpreter at both admission and discharge day (a difference of 9.4 per cent). (Source: Lindholm, Hargraves, Ferguson, & Reed, 2012)
- Central LHIN is a fast growing and diverse community; home to 820,580 immigrants, 49 per cent of the population for which English is not their first language (Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015). 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)
- Of the LHIN planning areas, the North York West area also has the highest rates for diabetes, congestive heart failure and hypertension; and the second highest rates for chronic obstructive pulmonary disorder, cancer and mental illness; and has been designated as a priority area for planning in Central LHIN.
- Central LHIN has a slightly higher proportion of residents who lived in low-income households (14.5 per cent) compared to the province (13.9 per cent). (Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015)
- 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 system.

Successes:

- In 2014-15, 166 Health Service Providers (including mental health and addictions, CCAC, and Diabetes Education Programs) received Indigenous Cultural Competency Training. In 2013-14, 80 per cent of Central LHIN staff and 90 per cent Board of Directors participated in Indigenous Cultural Competency Training.
- Funding for two Aboriginal Navigators who will help the Aboriginal community to better understand and navigate the system was awarded in late 2015.
- In partnership with Entité 4, Central LHIN adopted the Joint Action Plan for 2015-16. 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.
- Development of a model for a French Language Services navigator program in the North York West Area was piloted.

Goals

Goal 1: More equitable access to appropriate health services, including home and community services, and mental health and addictions services and supports, leading to better health outcomes.

Goal 2: Patients and their family are able to manage their chronic conditions.

Goal 3: Chronic conditions for these populations will be addressed in the most appropriate settings.

Goal 4: Patients will have an improved experience and more satisfaction with their care.

Goal 5: Increased access to culturally and linguistically competent services leading to improved outcomes.

Goal 6: Culturally diverse populations are better informed regarding existing resources.

Goal 7: Increased access to housing supports for sustaining housing tenancy for those living with mental health and addictions challenges.

Consistency with Government Priorities

The goals support the Ministry's priority of putting people and patients first by improving equitable access to care, resulting in better experiences and health outcomes.

Action Plans/Interventions

Action Plans	2016-17		2017-18		2018-19	
	Status	%	Status	%	Status	%
Complete development of North York West multi-year action plan and implement early initiatives (includes both MHA and physical health)	In progress	50	In progress	25	Completed	25
Develop and implement a regional model for delivery of Chronic Disease Prevention and Management (CDPM) programs that leverages the Diabetes Education Programs delivery model and aligns with primary care	In progress	25	Completed	75		
Improve access to services for the Aboriginal population in Central LHIN, including Georgina Island	Completed	100				
In collaboration with Entité 4, CE LHIN and TC LHIN, leverage current resources to establish and implement the MHA access pathway for Francophone services and leverage the Francophone navigator work to increase access to primary care services in French in the North York West area	In progress	50	Completed	50		

How will we measure success?

- Increased access to French Language health services (both physical and mental health) for the Francophone population.
- Aboriginal Navigators will support 200 Aboriginal residents living in the Central LHIN

What are the risks/barriers to successful implementation?

- Identification and engagement of the appropriate stakeholders to contribute to the continued work with the Francophone communities.
- Engagement with the Aboriginal population continues to present challenges that may impact on the ability to implement strategies to address the needs in this population.
- Change management in CDPM (Chronic Disease Prevention and Management) providers.

What is the plan to mitigate risk?

- Continue to engage Francophone communities through the collaboration with Entité 4.
- Work with the Aboriginal navigators to reach the community.
- Involve CDPM providers in the development of a shared CDPM plan for implementation across LHIN planning areas.

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

- Enhance the patient experience by promoting adoption of Telemedicine in Community Health Centres (CHCs) and Diabetes Education Programs (DEPs).
- Increase spread of remote monitoring technology for chronic diseases in different settings (e.g. Assisted Living and Retirement Homes).
- Implement the use of Tele-ophthalmology in Community Health Centres to improve the percentage of diabetic patients who are screened for retinopathy.
- Leverage provincial electronic tools that to promote sharing of information across providers for complex patients including Connecting Ontario, the provincial electronic health record.
- Continue the collaboration with Entité 4.

Additional Comments

- To respond to historical data that shows the Aboriginal community has been underserved, we will continue to provide Indigenous Cultural Competency Training to help Health Service Providers better understand the unique needs of Aboriginal residents and the most effective ways to begin and sustain important conversations about care with Aboriginal people.

Better Mental Health

Integrated Health Services Priority

IHSP Priority Description

Integrate a supportive system of programs and services to enhance the wellness of people with mental illness and addictions, and to promote and sustain recovery.

Current Status

Scope of Services, Providers and Clients Served:

- In 2013-14, there were 18,498 unscheduled emergency department visits for Central LHIN residents where the presenting issue was a mental health or substance use condition. (Source: *2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015)*
- Within Central LHIN hospitals, there are 171 inpatient adult mental health beds and 21 inpatient child/adolescent mental health beds. (*Source: Daily Census 2014-15 Q4*). In 2013-14 there were 4,976 admissions and 5,127 active cases who received treatment in adult designated mental health units in Central LHIN hospitals. (*2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015)*
- Short stay (31.2 per cent), schizophrenia and psychotic disorders (30.5 per cent), and mood disorders (26.7 per cent) accounted for the largest proportions of active cases in Central LHIN hospitals. (*2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015)*
- 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, crisis services, opioid addiction and problem gambling.
- Central LHIN agencies served over 23,200 individuals in 2014-15. *(Source: MOHLTC HIT tool)*
- It is estimated that 30 per cent of the Ontario population aged 15+ will experience a mental health/substance abuse problem at some point during their life. (*Source: Making It Happen: Implementation Plan for Mental Health Reform, Ontario Ministry of Health and Long-Term Care, 1999*)

- The majority of people entering and receiving substance abuse services are 25-34 years old – those entering and receiving problem gambling services are 45-54 years old. (*Source: Mental Health, Addictions and Problem Gambling – 2014 Ontario Landscape Report*)
- Data shows that alcohol abuse results in the highest percentage of repeat visits to the emergency department compared to other substances in Central LHIN. (*Source: Stocktake November 2015*)

Key Issues:

- Between 2010-11 and 2013-14, there was a 23 per cent growth in emergency department visits within the Central LHIN where mental health/substance abuse was the main problem diagnosis. (*Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015)*
- High-needs patients, including those with mental health conditions, have multiple chronic conditions and co-morbidities, and often access care through emergency departments.
- In 2014-15, support within housing and abuse programs had the longest median wait times among the community mental health services in Central LHIN for the next available treatment slot at 32 and 29 days respectively. The median wait time for abuse programs (29 vs. three days), case management (17 vs. five days), counselling and treatment (21 vs. 17 days), and early psychosis intervention (four vs. 0 days) were greater than the medians for Ontario. (*Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015)*
- Among the substance abuse services provided in Central LHIN in 2014-15, support within housing and residential treatment had the longest median wait times at 29 and 71 days respectively. (*Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015)*
- Limited access to services and supports for caregivers to reduce burnout and the need for crisis support for ailing family members.
- Central LHIN has the largest population of the 14 LHINS; however York Region's social housing supply relative to its population is the lowest in Ontario at 1.0 social housing units per 1,000 households and has just 191 units per 1,000 people diagnosed with mental illness and addictions issues. (*Source: Regional Municipality of York's 10-Year Housing Strategy, Housing Solutions: A Place for Everyone & MOHLTC Provincial Programs Branch*)

Successes:

- In Q1 2015-16, Ministry LHIN Accountability Agreement results, Central LHIN is one of four LHINs to have one of the lowest (24.2 per cent) repeat unscheduled emergency department visit rates within 30 days for substance abuse conditions in the province. (*Source: MLAA PI Supp-MH and SA, November 2015*)
- Central LHIN's median wait time for support within housing reduced substantially in 2014-15 compared to the previous Fiscal Year 335 days to 71 days. (*Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MoHLTC, June 2015)*
- Self-perceived mental health is rated as good or excellent at 74.9 per cent in Central LHIN residents, while the Ontario average is 70.9 per cent. (*Source: 2013 Canadian Community Health Survey (CCHS), Statistics Canada*)
- Embedding the patient voice in Central LHIN planning activities through patient and resident participation on planning groups such as the Mental Health and Addictions Summit in York Region, the Mobile Crisis Co-Responder Team, the Palliative Care working groups, and the Mental Health and Addictions Service Coordination Council in York Region.

- The Behavioural Support Unit at Cummer Lodge - a service for seniors with cognitive impairment - is fully operational and has an occupancy rate of 98 per cent. (*Source: BSO Quarterly Report, November 2015*)
- All six Central LHIN hospitals collaborated to complete development of a process to share availability of mental health/addictions inpatient beds.
- York Regional Police, York Region Emergency Medical Services, and York Support Services Network are implementing a new model of onsite mobile crisis response for York Region which will be evaluated.
- In 2015-16, Central LHIN began implementation of a Multi-Year Action Plan to increase access to an integrated, coordinated and efficient system of housing supports, treatment programs and supportive housing to promote and sustain recovery of those with moderate/serious and persistent disability in York Region.
- In 2015, Humber River Hospital opened its new site with expanded inpatient adult mental health beds to be phased in over seven years.

Goals

Goal 1: More efficient discharge from hospital after an admission for mental health and addictions.

Goal 2: Increased awareness of healthcare options, coordination and ease of navigation.

Goal 3: Increased access to housing supports and sustaining housing tenancy for those living with mental health and addictions challenges.

Goal 4: Increased ability for people with mental health and addictions to access needed services in a timely way.

Consistency with Government Priorities

The goals support the Ministry's priority of improving access and connecting services to deliver coordinated and integrated care for those experiencing mental health and addictions challenges, including a stronger link to primary health care. This includes decreasing visits to the emergency department, and improving access to services clients with mental health and addictions challenges.

Action Plans/Interventions

Action Plans	2016-17		2017-18		2018-19	
	Status	%	Status	%	Status	%
Evaluate the mobile crisis co-responder models to determine best practice and implement standardized model; evaluate impact of key initiatives of the MHA Action Plan and Service Coordination Council for York Region	In progress	75	Completed	25		
Continue to expand access to supportive housing	Completed	100				

How will we measure success?

- Repeat unscheduled emergency visits within 30 days for mental health conditions will decrease. (LHIN MLAA target: 16.3 per cent)

- Repeat unscheduled emergency visits within 30 days for substance abuse conditions will decrease. (LHIN MLAA target: 24.3 per cent)

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.
- Lack of affordable and social housing supply in York Region and North York West.

What is the plan to mitigate risk?

- Engage all impacted stakeholders, including clients and families early and throughout the change design and implementation process.
- Work with key housing stakeholders in the development of the Mental Health and Addictions Supports within Housing Action Plan for York Region.

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.
- Access to a single common wait list to better understand service capacity and gaps.
- Use technology (e.g. Telemedicine) to enhance access to mental health and addictions services such as psychiatry, counseling and case management.
- Leverage provincial electronic tools that foster coordinated care including: eNotification of primary care that a patient has been in hospital; eConsult between primary care and specialists; the Coordinated Care Tool, and access to provincial clinical data repositories such as the Integrated Assessment Record and ConnectingOntario.

4.3 LHIN Operations and Staffing – Templates B & C

Template B

LHIN operations Sub-Category ($)	2014/15 Actual	2015/16 Actual	2016/17 Allocation	2017/18 Planned Expenses	2018/19 Planned Expenses
Salaries and Wages	3,429,400	3,540,299	3,426,228	3,426,228	3,426,228
Employee Benefits	676,478	664,689	719,508	719,508	719,508
Total Compensation	***4,105,878***	***4,204,987***	***4,145,735***	***4,145,735***	***4,145,735***
Transportation and Communication					
Staff Travel	18,103	8,694	10,000	10,000	10,000
Governance Travel	2,870	3,396	5,000	5,000	5,000
Communications	46,550	29,681	35,294	35,294	35,294
Other	44,063	47,500	62,500	62,500	52,500
Total Transportation and Communication	***111,586***	***89,271***	***112,794***	***112,794***	***102,794***
Services					
Accommodation	280,487	329,588	288,293	292,000	302,000
Advertising	4,494	8,457	10,000	10,000	10,000
Consulting and professional Services	167,202	84,895	71,200	71,200	71,200
Governance Per Diem	37,375	46,650	85,000	85,000	85,000
LSSO Shared Costs	327,796	360,097	364,702	364,702	364,702
Other Meeting Expenses	37,384	35,679	34,300	34,300	34,300
Other Governance Costs	24,315	32,170	25,000	25,000	25,000
Printing & Translation	35,408	54,479	55,695	55,695	55,695
Staff Development	31,328	31,543	46,000	46,000	46,000
Total Services	***945,787***	***983,560***	***980,190***	***983,897***	***993,897***

Supplies and Equipment					
Equipment & Furniture	43,281	39,623	25,000	25,000	25,000
Office Supplies & Purchased Equipment	69,802	42,828	33,112	29,405	29,405
Total Supplies and Equipment	***113,083***	***82,451***	***58,112***	***54,405***	***54,405***
LHIN Operations: Total Planned Expenses	5,276,335	5,360,270	5,296,832	5,296,832	5,296,832
Annual Funding Target				5,296,832	5,296,832
Variance				0	0

ABP included all base funded programs (Operations, Diabetes, FLS, Aboriginal and ED/ALC Performance Lead)

4.4 Communications – Templates D & E

4.4.1 Integrated Communication Strategy

Business Objectives

The Vision for the Central LHIN is to create ***Caring Communities – Healthier People***. Our LHIN is 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."

Our Vision and Mission are central to the Integrated Health Service Plan (IHSP4) for 2016-2019 and provides the focus for six key priorities that will improve the patient and caregiver experience within the Central LHIN. These business objectives inform the Annual Business Plan for each of the three years included in the IHSP.

- **Better Seniors' Care**: Develop specialized strategies and support systems to help older adults stay healthy and independent at home for as long as possible. Reduce reliance on acute care by exploring and implementing other options that are senior-friendly and cost-effective.
- **Better Palliative Care**: Provide holistic, proactive and continuous care and support for patients with progressive, life-limiting illness and for their families. Support families through the entire spectrum of care before and after death by helping patients to live as they choose, and to die in their preferred location of choice – with quality of life, comfort, dignity and security.
- **Better Care for Kids and Youth**: Develop new partnerships and innovative models to bring specialized care closer to home, for children and youth.
- **Better Community Care**: Create stronger links to integrated community services and to primary care, to help patients recover and receive more of their health care at home, with safety and independence.
- **Better Care for Underserved Communities**: Create organized, integrated systems of care to improve early intervention and treatment of disease in neighborhoods where there are recurring patterns of chronic and acute or episodic health conditions. Develop partnerships that will improve long-term health by addressing the key factors that determine healthy outcomes.
- **Better Mental Health**: Integrate a supportive system of programs and services to enhance the wellness of people with mental illness and addictions, and to promote and sustain recovery.

The Communications Team will support the goals that are part of the first year of the implementation of our IHSP: ***Caring Communities, Healthier People***. As we advance these strategic directions, we will also work closely with the Ministry of Health and Long-Term Care, our Health Service Providers and other stakeholders to play a key role in the ongoing evolution of our health care system.

We will work to support provincial wide health system goals and objectives, and will maintain our focus on integrating the voice of the patient and the caregiver into our initiatives.

Patients First Messaging

- ***Patients First*** means a caring, integrated experience for patients and faster access to quality health for all Ontarians.
- ***The Patients First: Action Plan for Health Care, 2015*** sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre of our health care system by improving the health care experience:
  - **Access** – Improve access – providing faster access to the right care.
  - **Connect** – Connect services – delivering better coordinated and integrated care in the community closer to home; providing better home and community care.
  - **Inform** – Support people and patients – providing the education, information and transparency Ontarians need to make the right decisions about their health.
  - **Protect** – Protect our universal public health care system – making decisions based on value and quality, to sustain the system for generations to come.
- As the next logical step in the ***Patients First: Action Plan for Health Care, 2015,*** Ontario proposes a path towards providing better access to care no matter where you live by better connecting health care services.

Local Messaging

- The Central LHIN plans, funds and integrates local health care services to improve access to ***the right care, at the right time and in the right place.***
- Central LHIN is building a better health care system by focusing on provincial priorities that can be shaped at the local level, and adapted to local population health needs.
- By implementing our six strategic priorities – ***Better Seniors' Care; Better Palliative Care; Better Care for Kids and Youth; Better Community Care; Better Care for Underserved Communities; and Better Mental Health*** – the Central LHIN is changing and strengthening the system to improve the health care experience for patients and families.
- Working closely with our Health Service Providers and other partners, the Central LHIN will shape a strong local health care system because '**Together*, we're better! '***

Communication Objectives

- Help our staff to understand the evolution that is underway – and of their pivotal role in moving our priorities forward.
- Build confidence among the people in the Central LHIN that progress is being made in key strategic areas to improve access to health services, and to improve the patient experience. Increase understanding and awareness of key programs and initiatives as they are implemented.
- Advance the implementation of our strategic priorities through ongoing communication and engagement with the key stakeholders and Health Service Providers who have a pivotal role in moving these priorities forward – and inspiring them to future action.

Provincial Context

Ontario's health care system continues to experience an evolutionary change. The LHINs are aligning strategic priorities for 2016-2019 with those of ***Patients First: Action Plan for Health Care, 2015*** and are working collaboratively to continue to advance the objectives included in the Premier's Mandate Letters. (January 2012 – to Minister of Health and Long-Term Care and to the Associate Minister of Health and Long-Term Care, Long-Term Care and Wellness.)

Our initiatives will be characterized by the priorities that are included in these letters:

Minister of Health and Long-Term Care:

- Putting Patients at the Centre – the Right Care, Right Place, Right Time
- Moving Forward on Accountability and Transparency
- Collaborating on Shared Responsibilities Across Government

Associate Minister of Health and Long-Term Care (Long-Term Care and Wellness):

- 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

The priorities in these Mandate Letters are integrated into our ongoing business objectives and plans for the future. Additionally, in partnership with other LHINs, the Central LHIN plays a critical role in implementing key provincial initiatives at a local level: Health Links, Palliative Care, Mental Health Supportive Housing, Home and Community Care Modernization, the development of LHIN planning areas, and primary care renewal and reform.

Last year in February 2015, the release of ***Patients First: Action Plan for Health Care, 2015*** provided another important platform for our future work as LHINs. It builds on a strong foundation set by Ontario's original Action Plan for Health Care in 2012, and strengthens the government's commitment to put patients first by improving their health care experience.

The 2012 Action Plan led to a number of important successes, and ***Patients First*** has mobilized us to achieve additional accomplishments. But there is still more work to do to strengthen the health care system – making it more transparent, accountable and sustainable so it will be here, when needed, for generations to come.

Using ***Patients First*** as a compass, the Central LHIN developed the 2016-2019 Integrated Health Service Plan - ***Caring Communities, Healthier People***. Implementation of the plan will bridge our local system to the next phase of evolution, and advance provincial health care priorities.

There are two other important considerations at the provincial level that will inform our ongoing communications strategy. The release of the LHIN Value for Money Audit by the Office of the Auditor General of Ontario and the subsequent recommendations will require ongoing communication and updates as we work to move these forward.

Also top-of-mind is the public release in December 2015 of **Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario.** The public consultation that is part of this proposal will provide another valuable opportunity for the LHINs to continue to listen to the voice of the patient and the caregiver, and to integrate what we hear into our ongoing planning.

Audiences

Internal:

- Central LHIN Board of Directors
- Employees of Central LHIN

External:

- Patients and caregivers in Central LHIN with an emphasis on seniors, our largest population
- Physicians of Central LHIN
- Health Service Providers
- MPPs
- Non-funded partners
- Municipalities
- Primary care
- Media
- Thought leaders within Central LHIN
- Associations and advocacy groups

Strategic Approach:

The current level of limited communication resources within the Central LHIN demand that we exercise creativity to maximize impact. Our intent and approach in 2016/17 is to leverage the strengths of our Health Services Providers to assist us in deploying many of our communication deliverables.

To support our business and communication objectives, we will:

- Develop communication templates and guidelines for initiatives that are part of our IHSP priorities. Monitor and review progress to key milestones to make sure that public awareness and understanding is aligning with our Key Messages and our communication objectives.
- Leverage our existing mechanisms – website, e-newsletter, Twitter feed, engagement sessions, standing committees etc. – to provide regular communication updates.
- Seek out ongoing opportunities to profile Central LHIN successes. Use these accomplishments as a way to recognize our Health Service Providers and partners, and to demonstrate our alignment with provincial health care priorities.
- Manage and respond to ongoing issues with transparency, responsibility and integrity
- Integrate the voice of the patient and caregiver into our communications whenever possible – using their stories and experiences to inspire action and keep our system grounded in our vision for what is possible.

Tactics

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

- Presentations from the CEO to key stakeholders
- LHINfo Minutes
- LHINTouch electronic newsletter
- CEO blog
- Media materials and events, including those hosted by our MPPs
- Distribution of targeted communication materials, with appropriate context, to our HSPs
- Videos, posted to our website
- Website content
- Twitter feed
- Brochures and flyers

Feedback

The success of our communication initiatives will be monitored in these ways:

- Website analytics
- Uptake of key messages in local media
- Regular communication consultation with our Citizens Health Advisory Panel
- Feedback during MPP visits and other forums
- Questions and comments received in the Central LHIN mailbox account
- Followers on Twitter

4.4.2 Community Engagement Plan

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 to improve the health care system through the interaction, sharing and gathering of information with our stakeholder communities. This summary highlights the community engagement framework and key activities planned by Central LHIN to engage our stakeholders in support of the projects and planning activities outlined in our Annual Business Plan for 2016-17. Engagement is a dynamic process and this plan will change and evolve as new opportunities or priorities emerge through the year.

Engagement Strategies

Central LHIN supports the concept of a continuum of engagement strategies. Our engagement strategies fall within this framework, with strategies chosen to help us achieve specific outcomes, tailored to the stakeholder group and the requirements of our projects and planning activities.

Inform and Educate: Provide accurate, timely, relevant and easy-to-understand information to the stakeholders. Provides information about the LHIN, and contextual information regarding issues, alternatives, and/or solutions. Outcome**:** Information "Push" / No feedback.

Gather Input: Obtain feedback on analysis, proposed changes (such as new programs), service model design options or service evaluation. Designed to allow opinion / concerns / suggestions from stakeholders regarding the matter at hand. Outcome: Information "Pull" / Feedback is 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. Outcome: 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 and to co-design programs and solutions. 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. Outcome: Knowledge transfer-exchange /solution co-design. Final outcome directly reflects 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; this includes our Health Service Providers and other service partners as well as patients, family caregivers and our Central LHIN communities. Our stakeholders are affected by the decisions we make and are invited to be involved in the engagement process so that we can make better decisions together.

Stakeholder Priority Groups:

- **Residents of Central LHIN** as consumers of health care services and supports
- **People with lived experience** of Mental Health and Addictions, Palliative Care and Seniors Care services
- **North York West Community**
- **Region of York/City of Toronto/County of Simcoe**
- **Primary care providers** (physicians, nurse practitioner led clinics, community health centres, all physician group practice types)
- **Community Support Service agencies, Community Care Access Centre, and Mental Health and Addictions agencies**
- **Long-Term Care Homes and Hospitals**
- **Indigenous peoples** and/or representatives of this population either self-identified or identified through the development of our engagement strategy
- **Francophone communities through the partnership with Entité 4**
- **Other Stakeholders directly or indirectly involved in Central LHIN projects or activities** as identified through our Annual Business Plan

Working Groups/Committees/Councils

Many of our stakeholders are invitied 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 2016-17 are as follows:

- **Citizens Health Advisory Panel (CHAP),** established in fiscal 2013-2014, gives voice to the community in Central LHIN's system planning initiatives. This panel serves as a forum for dialogue with community members as they advise the LHIN on how to achieve person-centred health care in designing programs within the local health system context.
- **Health Professionals Advisory Committee (HPAC)** is the only committee required by legislation (Local Health System Integration Act, 2006 or Ontario Regulation 267/07). HPAC membership composition is directed by legislation and is constituted with representatives of a variety of health professional groups. HPAC provides advice to the LHIN on achieving patient-centred care in designing programs within the Central LHIN context.
- **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.
- **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.
- **Palliative Care Coordination Council –** The Central LHIN has established a Central LHIN Palliative Care Coordination Council to advise the LHIN and to oversee the implementation of the Central LHIN Palliative Care Action Plan.
- **eHealth Advisory Council -** Central LHIN's Integrated Health Service Plan 2016-2019 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 in 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 Accountability Agreement (MLAA) and provide guidance and advice on eHealth implementations.
- **The Mental Health and Addictions Service Coordination Council –** Canadian Mental Health Association – York Region is responsible for the implementation of the Central LHIN Mental Health and Addictions Supports within Housing Action Plan for York Region, working closely with the Central LHIN. To guide the implementation, CMHA-YR is required to establish and support the Mental Health and Addictions Service Coordination Council (SCC). The mandate of the SCC is to collaborate and provide guidance on how to implement the Action Plan by March 31, 2019.
- **The Central LHIN Chronic Disease Prevention and Management Service Coordination Committee** established in 2016. The purpose of the CDPMSCC is to provide advice to the Central LHIN on the coordination and integration of service delivery at the local level to achieve equitable access to chronic disease prevention and management programs across the LHIN planning areas. The Committee will take a population-based approach, including specific focus on high-needs and at risk populations. This Committee will advise the LHIN by engaging local stakeholders regarding the local health system's needs.
- **Community Sector Working Group (CSWG) -** The mandate of the CSWG includes supporting the Central LHIN IHSP priorities as well as improving Central LHIN's MLAA performance. It also advises on ways to advance the local health system to achieve desired outcomes and provides an enhanced understanding and

insights into sector specific issues within Central LHIN. Meeting minutes and a communique are published to the entire community sector so that all community HSPS are apprised of the meeting discussions.

- **Central LHIN Alternate Level of Care (ALC) Collaborative –** The ALC Collaborative is a dedicated team comprised of hospital, CCAC, and Central LHIN staff intended to provide focused and collective resources to enhance the flow, efficiency, effectiveness and system capacity across the continuum for the benefit of Central LHIN patients. The ALC Collaborative will actively engage with all Central LHIN Hospitals, the Central CCAC and other system partners, as appropriate throughout its two year funding period (December 2015 to December 2017).
- **Rehabilitation Care Capacity Planning Task Group –** In collaboration with the all Ontario LHINs and the Rehabilitative Care Alliance (RCA), the Central LHIN implementing a definition framework for levels of rehabilitative care, and the Capacity Planning Framework developed by the RCA; the target date for implementation is March 2017. The goal is to promote consistency for rehabilitative care services across Ontario, to establish a basis for the public and referral sources to understand expected levels of care, and to inform LHIN capacity planning for rehabilitative care services. Providers of rehabilitative care services in Central LHIN, including all Central LHIN hospitals, Central CCAC, Community Physiotherapy Clinics, Community Health Centres and Outpatient Rehabilitation services have been engaged to complete a current state analysis and ongoing engagement is anticipated until March 2017.

2016-2017 Engagement Activities

In alignment with the Annual Business Plan, the following specific engagement activities are planned for the 2016/17 year:

ABP Initiative	Stakeholder group	Engagement Goals	Format	Fiscal Quarter
Primary Care Engagement	Providers and recipients of primary care Other health service providers, particularly home and community and mental health and addictions	Inform, educate, gather input, Consult, collaborate	Multiple; may include surveys, focus groups, planning exercises, newsletters, posting on website	Throughout the year
Implementation of Personal Support Service and service coordination policy guidelines	Patients and family caregivers receiving Community Service Support and Central CCAC services; Community Service Support (CSS) agencies and Central CCAC	Inform, educate, gather input Consult, collaborate	Multiple; may include surveys, focus groups, planning exercises, newsletters, posting on website In addition an implementation Steering Committee will be formed with representatives from the stakeholder groups to oversee the implementation	Throughout the year

Engagement of Specific Populations

Francophone Community*:* Central LHIN has approximately 1.9 per cent of its population who identify themselves as Francophone. In the Central LHIN two areas are "Designated" communities under the French Language Service Act (FLSA): North York (City of Toronto) and the newly designated city of Markham (York Region).

The Central LHIN is required to engage the Francophone community by engaging the French Language Health Planning Entity (FLHPE) (section 16 of the Local Health System Integration Act (LHSIA)). The areas where the Central LHIN shall engage our respective FLHPE is as follows:

- The methods of engaging the French-speaking community in the area;
- The health needs and priorities of the French-speaking community in the area, including the needs and priorities of diverse groups within that community;
- The health services available to the French-speaking community in the area;
- The identification and designation of health service providers for the provision of French language health services in the area;
- The strategies to improve access to, accessibility of and integration of French language health services in the local health system and the planning for and integration of health services in the area.

To achieve these objectives, Entité 4, Central, Central East and North Simcoe Muskoka LHINs developed a joint action plan. 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. Central LHIN supports the provision of French Language Services through a fully bilingual website and public materials such as annual reports, news releases, etc. that are available in French.

Aboriginal Peoples*:* Aboriginal people represent 0.5 per cent of the LHIN's population. While a portion of this population lives on Georgina Island, the majority live off-reserve in Central LHIN. Central LHIN developed an Aboriginal Engagement and Cultural Competency Strategy in 2015-16. The plan will support the foundation to build trust and rapport with Aboriginal people. This will be done through a combination of direct engagement with the Aboriginal community in the LHIN, and through health service providers and social service agencies that primarily care for this population.

The intent is to establish the LHIN as a partner to Aboriginal people to assist the community in building capacity where health needs are identified. As well, Cultural Competency Training was made available to the LHIN Board of Directors, staff and Health Service Providers in 2015-16, with the intent to provide on-going training.

Central **LHIN** | **RLISS** du Centre

Ontario

Local Health Integration Network

Réseau local d'intégration des services de santé