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

Annual Business Plan

2017-2018

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

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1. Context

A. 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.

With the December 2016 passage of the *Patients First Act* through the Ontario Legislature, LHINs will have an expanded role in improving and integrating the planning and delivery of front-line health care services. LHINs will be responsible for organizing and managing home and community services, mental health services in the community and for planning primary care. Once fully implemented the changes supported by the *Patients First Act* will:

- Improve care for patients and access to primary care for people in Ontario;
- Improve local connections between primary care providers, inter-professional health care teams, hospitals, public health and home and community care to ensure a smoother patient experience and transitions;
- Streamline and reduce administration of the health care system and direct savings into patient care;
- Enhance accountability, through LHINs being the single point of accountability for the integration of care within LHINs and LHIN sub-regions;
- Strengthen the voices of patients and their families in their own health care planning;
- Increase the focus on cultural sensitivity and the delivery of health care services to Indigenous people and French-speaking people in Ontario

As the LHIN prepares for transition with the Central Community Care Access Centre (CCAC) to a new LHIN, the top priority is to provide seamless, uninterrupted service delivery to patients and families. To support this transition, Central LHIN is committed to meeting the priorities as identified in the Minster's Mandate Letter.

Central LHIN's Integrated Health Service Plan (IHSP) for 2016-2019 is the roadmap to move us forward toward advancing the *Patients First: Action Plan for Health Care* and achieving our vision of *Caring Communities, Healthier People*. The Central LHIN works with patients, families, Health Service Providers, non-funded partners such as municipalities and Public Health Units to build a strong, sustainable system that will be here to serve and to support future generations.

Central LHIN continues to create a more integrated health care system by advancing the IHSP and aligning provincial priorities with local initiatives in six areas of focus: Better Seniors' Care; Better Palliative Care; Better Care for Kids and Youth; Better Community Care; Better Care for Underserved Communities; and Better Mental Health.

Our Strategic Priorities

The Central LHIN 2017-18 Annual Business Plan (ABP) outlines the implementation of the second 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.

B. Overview of Central LHIN's Current and Future Programs and Activities

In 2017-2018, the Central LHIN will fund 93 Health Service Providers approximately $2.1 billion through 99 Service Accountability Agreements *(Source: Central LHIN MSAA/LSAA/HSAAs)*.

The number of providers funded in each sector is as follows:

- Seven public* and two private hospitals
- 46 Long-Term Care Homes
- 31 Community Support Service (CSS) providers
- 23 Mental Health and Addictions (MHA) service providers
- Two Community Health Centres (CHCs)

**7 public hospitals includes West Park Health Centre (Ventilator Beds)*
(Source: Allocation and Payment Tracking System (APTS) as of June 2016)

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 2016-19, *Caring Communities, Healthier People*.

Better Seniors' Care

- Based on the Long-Term Care (LTC) Capacity Plan, develop and implement community-based alternatives to traditional institutional LTC for seniors.
- Continue to develop, implement and evaluate sustainable improvement strategies that enhance system capacity for patients waiting for Alternate Levels of Care (ALC) in Central LHIN hospitals.
- Continue to implement, evaluate and spread assess/restore pilot projects to enhance rehabilitative and restorative care services that prevent functional decline for frail elderly patients.
- Strengthen the alignment between Specialized Geriatric Services and Long-Term Care Homes within sub-region planning areas, to improve resident care through stronger coordination and access to service delivery.
- Continue to develop and formalize the Central LHIN dementia and caregiver support strategy.

Better Palliative Care

- Continue to implement the Central LHIN Palliative Care Action Plan in alignment with sub-region planning through our Regional Palliative Care Network.
- Develop a comprehensive Palliative Care Strategy for Central LHIN that incorporates community need within a broader spectrum of palliative and end of life care.
- Continue to operationalize Ministry-approved residential hospices.

Better Care for Kids and Youth

- Review 2017 evaluation of the Cross Sector Complex Care Model and investigate expansion.
- Evaluate regional respite care options for young adults (18+) with medically complex care needs.

Better Community Care

- Partner with primary care providers and specialists to improve patient connectivity and access to care within the six sub-regions in Central LHIN.
- Strengthen community based collaborative care through sub-region initiatives to improve the continuity of care for patients, clients and caregivers receiving services in Central LHIN.
- Begin implementation of Central LHIN's three year strategy to reduce wait lists and service pressures for Acquired Brain Injury (ABI) and Attendant Outreach services.
- Continue to improve consistency and equity in service provision for home care clients.

Better Care for Underserved Communities

- Continue to work with Public Health Units and explore opportunities to collaborate on joint priorities at neighbourhood, sub-regional and regional levels.
- Continue to identify, support and coordinate services for priority neighbourhoods within LHIN sub-regions (e.g. North York West) that address gaps in equity and access to care.
- Develop a comprehensive sub-region based strategy for delivering coordinated and accessible Chronic Disease Prevention and Management (CDPM) programs.
- Continue to co-design and support solutions for improved access to culturally appropriate services with Central LHIN urban Indigenous communities and those residing on Georgina Island.
- In collaboration with Entité 4, Central East LHIN, Toronto Central LHIN and Central LHIN leverage current resources to implement the Mental Health and Addictions access pathway for Francophone services.

Better Mental Health

- Evaluate the impact and efficiency of mobile crisis co-responder models for possible expansion throughout Central LHIN.
- Partner with stakeholders to develop and implement a three-year Addictions Strategy aligned with the provincial Opioid Strategy.
- Integrate access to mental health and addictions services throughout the Central LHIN with a focus on waitlist management, prioritization and standardized eligibility criteria.

Additional LHIN Operational Activities that Support Achieving Our Mandate

Capital Redevelopment Planning

Central LHIN is the most populous LHIN in Ontario with the second highest growth rate. In order to meet the demand for services in the future and maintain aging infrastructure, all of our public hospitals are involved in capital projects either in early planning stages, building stages, or post-build ramp up. The LHIN works closely with the hospitals and the Ministry of Health and Long-Term Care (MOHLTC) to plan for programs and services to support the needs of Central LHIN residents now and into the future.

Some of the major projects undertaken by our hospitals to expand capacity in the LHIN include:

- **Mackenzie Health:** A second site is currently being built in Vaughan, and is expected to open in 2020-21. Overall, the capacity at Mackenzie Health is expected to increase by over 200 inpatient beds and an expanded access to emergency and outpatient services.
- **North York General Hospital:** The hospital is using its own funds to develop a new location for its ambulatory and transitional mental health services for children, adolescents, young women and their families. The new Phillips House site will improve patient access to these services as they will be consolidated into one easy-to-access location.
- **Southlake Regional Health Centre:** The hospital is using its own funds to improve patient access to diagnostic imaging services by renovating its Diagnostic Imaging Department and Cardiac Catheterization Laboratories. These renovations are intended to improve patient experience and allow the hospital to modernize its diagnostic equipment.

Long-Term Care Homes

Of our 46 Long-Term Care Homes, 21 will undergo redevelopment to upgrade their facilities to current design specifications to improve quality of care and comfort of residents by 2025. The LHIN will work with the Ministry and LTC Home providers as they plan for redevelopment to minimize disruption.

Performance Management

Central LHIN is responsible for developing local health care system funding plans, performance targets and accountability agreements for 96 local Health Service Providers (HSPs) across multiple sectors.

While the LHIN is reliant on HSPs to provide quality care that achieves performance deliverables, a risk-based approach to managing and monitoring performance by providing advice and support to resolve issues in system performance is utilized.

Program Monitoring

In addition to Health Service Provider performance management, the LHIN has implemented a program monitoring process for selected initiatives 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 will be 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 Patients First Action Plan*
3. *Access & connect – to align with the Patients First Action Plan*
4. *Program mandate – to ensure that the program is achieving the intended program objectives*

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

C. 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. By 2025, Central LHIN is projected have over 400,000 seniors (412,345). 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.
	2025 (Projected)		
	2035 (Projected)	**23%**	
Children (0-4 years)		**5.0%**	Central LHIN has the highest number 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		**1.9%**	The percentage of our population who are Francophone (Inclusive Definition*) *persons whose mother tongue is French, plus those whose mother tongue is neither French nor English but have a particular knowledge of French as an Official Language and use French at home.
Indigenous		**0.5%**	The percentage of our residents who are Indigenous, with the majority of these living in urban centres.

(Source: 2016-2019 IHSP Pan-LHIN Environmental Scan, MOHLTC, June 2015; 2011 Census-based Population Estimates and Projections for Local Health Integration Networks, Ministry of Finance, 2015; Better Outcomes Registry & Network (BORN) Ontario, 2011-12; Inclusive Definition of Francophone (IDF), 2011 Census IDF by Office of Francophone Affairs.)

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 Central LHIN has the highest number of seniors in the province with seniors aged 85+ projected to increase by 59 per cent in the next 10 years. Seniors aged 85+ are those most likely to have complex needs and require more health services. Central LHIN residents, including seniors and those with complex care needs, require ongoing coordinated 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, home and community health services, mental health and substance abuse services, palliative services, Long-Term Care and self-management support is imperative. New and emerging initiatives are underway to provide a system of collaborative care within our sub-region planning areas. Some examples include:

- Implementation of the Central LHIN Long-Term Care Capacity Plan that provides recommendations for investment into community based alternatives to traditional institutional Long-Term Care Homes;
- Improved access and delivery of palliative services through new residential hospice beds and sub-region based regional palliative care teams;
- Integrated access to mental health and addictions services throughout Central LHIN;
- Improved patient care coordination through better linkages between primary care and home/community providers;
- Development of a new Central LHIN dementia and caregiver support strategy

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

Central LHIN encompasses a mix of rural and urban communities with five per cent of residents living in rural communities and 89 per cent living in large urban centres *(Source: 2016-2019 IHSP Pan-LHIN Environmental Scan, MOHLTC, June 2015)*. The ability to deliver care in rural settings presents challenges to receiving the right care closer to home. Central LHIN is working to improve this through the continued expansion of the Telehomecare and Telemedicine models of care, increased collaboration with Public Health Units and Primary Care in the sub-region planning areas, and through collaboration with the Ministry and HealthForceOntario to meet local health human resource needs.

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 newcomers in the province. Central LHIN is home to a small population (0.5 per cent) of Indigenous people (both urban and on reserve), and approximately 1.9 per cent of the population is Francophone *(Source: 2016-2019 IHSP Pan-LHIN Environmental Scan, MOHLTC, June 2015).* These characteristics contribute great depth, complexity and richness to our communities making this feature an important priority for Central LHIN. It is essential for all service providers to respect and integrate culturally appropriate solutions into our health care strategies to meet the needs of all residents of our 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 *(Source: 2016-2019 IHSP Pan-LHIN Environmental Scan, MOHLTC, June 2015)*. In addition, certain sub-regions and neighbourhoods within sub-regions have greater socioeconomic challenges and higher rates of chronic disease and health care utilization than others.

Planning at a sub-region level enables provides and partners to develop a common understanding of specific population characteristics, service capacity and areas in need of improvement. Sub-region planning highlights variation across the LHIN to better address health disparities, health system performance and the ability to meet the needs of our communities. To be successful, Central LHIN will rely on healthy collaborations among our many system partners including public health units, health service providers (both funded and non-funded), municipalities, Entité 4, Indigenous community leaders, patients and families.

Patient Acuity

Central LHIN emergency departments see a large proportion of high acuity patients. From April 2016 to December 2016, Central LHIN ranked as the 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: Access to Care, ER Fiscal Year Report, 2016)*. This is an indication of the ongoing increase in demand placed on Central LHIN Health Service Providers. Additionally, there is an increasing percentage of Central long stay home and community clients that are high/very high needs: 44 per cent in 2010-11 vs 75 per cent in 2015-16 *(Source: Central CCAC based on RAI scores, February 2017).*

High birth rate and proportion of children with medical complexity

Central LHIN has the second highest birth rate and the highest number of children aged zero to four of all of the LHINs *(Source: Ontario Hospitals Maternal-Child Benchmarking Report, 2014; 2011 Census-based Population Estimates and Projections for Local Health Integration Networks, Ministry of Finance, 2015)*.

Central LHIN also has the second highest number of children with medical complexity in the province *(Source: Provincial Council of Maternal and Child Health: Health Care Symposium Report, ICES, January 2012)*. Going forward, it will be important to address capacity needs for health services for all residents, both young and old.

2. French Language Services (FLS)

According to the inclusive definition of Francophones, over 31,000 Francophones live in Central LHIN *(Source: Inclusive Definition of Francophone (IDF), 2011 Census IDF by Health Analytics Branch, MOHLTC).*

In order to meet the requirements of the Local Health System Integration Act (LHSIA) Section 16, Central LHIN has continued to work towards developing a strong relationship with the community and a better understanding of their needs by collaborating closely with our local French Language Health Planning Entité (FLHPE), Entité 4.

As part of Patients First implementation, Central LHIN will be taking on the responsibility for the provision of home and community care, ensuring that services are available in French and in accordance with the *French Language Services Act, 1990*. To meet the needs of the francophone community, a new bilingual auto-attendant will be implemented at the home and community call centre to provide the public with an option to select services in French. When this option is selected, calls will be directed to onsite French speaking staff during business hours. In addition, translation services are accessed as required.

Francophone patients who are actively receiving services will be assigned to a French Care Coordinator. It is important to note that Service Provider Organizations are contractually obligated to deliver all required services to a patient in French if indicated in the Patient Care Plan.

A three-year strategy *"Towards Equitable Access to French Language Services*" was developed by Entité 4, Central East, Central and North Simcoe Muskoka LHINs, with the following priorities:

- Increasing access to FLS primary care and chronic disease prevention and management
- Enhancing access to mental health and addiction services for Francophone populations
- Enhancing access to home and community care services for Francophone populations
- Enhancing access to palliative care for Francophone populations

Central LHIN, in partnership with Entité 4, will continue to measure and monitor HSP's capacity to deliver services in French. A reporting tool to better understand the FLS capacity amongst HSPs is being utilized to implement the Active Offer and proceed towards FLS identification and designation where appropriate The Central Healthline has been enhanced to identify HSP's who actively offer French Language Services. Additionally, a tool kit will be available on the Central LHIN as a reference on the implementation of the Active Offer.

Central LHIN and Entité 4 hosted an interactive webinar on the Active Offer to all HSP's. Furthermore, Entité 4 is currently supporting all HSP's with French language capacity in the Central LHIN, focusing on raising awareness about the importance of providing French language services which are safe, respect the principles of equity and are linguistically and culturally appropriate to the needs and priorities of the Francophones.

As per our Joint Action Plan, and through the collaboration between Toronto North Support Services Network and York Support Services Network, an initiative was piloted to facilitate access to linguistically

and culturally appropriate community mental health and addictions services to support the Francophone community.

Central LHIN created a new FLS Health Navigator position in the North York West sub-region to increase access to primary care, case management and chronic disease prevention and management services in French.

In preparation of the City of Markham's designation under the *French Language Services Act* (FLSA) in July 2018, Central LHIN will be working with Entité 4 for the development of French Language Services to provide equitable access to health services to the local Francophone population.

Central LHIN will continue to partner with Central East, Toronto Central, Central West and Mississauga Halton LHINs to develop and implement a cognitive health project model which will focus primarily on early detection, intervention and treatment for seniors experiencing slight cognitive health issues.

Efforts will continue to focus on reaching the growing number of Francophones (including newcomers) who face equity issues by developing relationships with community leaders and agencies serving this population.

3. Indigenous Peoples

Central LHIN is home to approximately 9,000 Indigenous people, representing 0.5 per cent of the population. The Chippewas of Georgina Island, comprised of approximately 200 residents, is Central LHIN's only First Nations on-reserve community. While a portion of Central LHIN's Indigenous population lives on Georgina Island, the majority are living off-reserve, primarily in semi-rural and smaller communities in northern York Region and south Simcoe County *(Source: National Household Survey, 2011).*

Central LHIN recognizes that Indigenous people have a greater burden of illness than the general population that is exacerbated by barriers to equitable access to health services.

Central LHIN develops an Indigenous Engagement and Cultural Competency Training Plan each year that identifies various Indigenous stakeholders in the local community. For the 2016-19 Integrated Health Service Plan (IHSP) and subsequent Annual Business Plans, engagements have included face-to-face meetings with Georgina Island and NinOsKomTin (a local urban Indigenous group) in addition to other Indigenous and non-Indigenous stakeholders to understand key considerations within sub-region planning contexts.

Central LHIN funded two Indigenous Navigators in February 2016 to support the local community in navigating health care services, in particular mental health and addictions, chronic disease (diabetes) and access to primary care. Indigenous stakeholders were engaged in this proposal and the program was implemented. Central LHIN is exploring innovative and improved sustainable funding mechanisms to support Indigenous people living both on and off-reserve by asking local Indigenous leaders what their community needs are and how best to meet those needs.

Central LHIN will continue to partner with Indigenous communities to further understand how to support and co-design culturally appropriate, connected and safe services for improved health outcomes.

Central LHIN has invested in Indigenous Cultural Competency Training over the past three years to support Health Service Providers better understand the importance of adopting culturally safe practices. This has been done in conjunction with the Ontario Federation of Indigenous Friendship Centres. In addition, Central LHIN was allocated 273 online Indigenous Cultural Safety training seats in 2016-17 (by the Ministry of Health and Long-Term Care) for Health Service Provider staff for a more in-depth education opportunity.

4. Operationalizing the Priorities

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 *(Source: 2016-19 IHSP Pan-LHIN Environmental Scan, MOHLTC, June 2015*).
- The Central LHIN funds 46 Long-Term Care Homes (LTCHs) encompassing over 7,200 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).
- In order to increase the capacity of LTCHs, Central LHIN has funded 84 interim beds, including a 20 bed specialized hemodialysis unit, from discretionary funds. The LHIN has 94 convalescent beds, 39 of which are funded from LHIN discretionary funds.
- Central LHIN funds 237 Home First spots through home and community care. In fiscal year 2015-16, 1,894 clients received care and services through the Home First program *(Source:*

*Central CCAC 2015-2016 Annual Report).*The average age of Home First patients is 82+ and about 96 per cent are high needs patients. Previously, many of these clients would have been discharged from the hospital directly to LTC.

- 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.
- Central LHIN funds 10 Community Support Service (CSS) providers to deliver assisted living under the Assisted Living for High Risk Seniors Policy. These providers service over 1,900 seniors who reside in their home setting 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 for persons with physical disabilities and acquired brain injuries as well as those requiring attendant outreach services.
- Two Integrated Funding Model Pilot Projects are currently in year two of the three-year pilot (2015-2018). They provide the following services to seniors:
    - ***One Client, One Team: Central and Toronto Central LHIN Integrated Stroke Care*** is led by 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 18 weeks post-discharge. The approach includes 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, which increases demand for services.
- System navigation challenges for patients, caregivers and providers in identifying where and how to receive timely care in the right setting once discharged from hospital.
- Gaps in service and care delivery for seniors with complex conditions resulting in more Alternative Level of Care (ALC) days in hospital (e.g. the frail elderly with behavioural 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 *(Source: LTCH System Reports, December 2016).* Central LHIN has the second lowest beds per seniors aged 75+ compared to 14 LHINs. The ratio currently is of 60.9 beds per 1,000 senior population aged 75+, whereas Ontario has 80.95 beds per 1,000 senior population aged 75+. (*Source: Long-Term Care Home System Report as of February 28, 2015, MOHLTC, Health Data Branch, HSIM Division).*

- The Ministry-led Enhanced LTCH Renewal Strategy requires older homes that do not meet current design standards to redevelop over the next 10 years. Twenty-one Central LHIN homes are eligible for redevelopment which may result in the temporary closure and/or loss of capacity of LTC beds. Reasons why redevelopment may effect LTCH bed stock include disruption while homes renovate or rebuild in a new location; home requiring to downsize to meet current design standards requiring larger resident living space; or the potential relocation of beds outside of Central LHIN if providers choose to do so.

Successes:

- Central LHIN has developed a LTC Capacity Plan to develop alternatives to "bricks and mortar" LTCHs for residents in our LHIN. This plan will inform future community investments. A key part of the plan is expanding and enhancing both Assisted Living and Adult Day Programs. This is a multi-year plan, but some of the work done in 2016-2017 includes:
    - Expansion of the Assisted Living Program by funding an Enhanced Assisted Living model of care for an additional 133 high risk seniors. This expansion reduced the waitlist for personal support services and enabled more seniors to live independently in their home setting. In addition to monitoring client satisfaction and ED visits, the LHIN is monitoring this program for LTCH admissions to assess whether this model of care is delaying or preventing admissions to LTC, and thus functioning as an alternative to institutional LTC.
    - Expansion of four Adult Day Programs and addition of Foot Care Services to these programs in order to provide more comprehensive services.
    - An Enhanced Adult Day Program working group has been established to make recommendations on the expansion and enhancement of Adult Day Program for seniors in the Central LHIN.
- The Central LHIN funded an ALC Collaborative composed of hospital, CCAC and LHIN staff to develop and implement focused and sustainable improvement strategies to enhance system capacity and facilitate patient flow across the care continuum. The ALC Collaborative has completed a comprehensive current state analysis to identify specific system gaps. The ALC Collaborative led the development of the following projects to improve patient access to the right care at the time and in the right place:
    - Completion of the *ALC Avoidance Self-Assessment Tool* by all Central LHIN hospitals and Central CCAC to review ALC management and avoidance practices within the organization and at systems level;
    - Implementation of a *Discharge Planning Dashboard* that captures the journey of high-risk patients in hospital from admission to discharge, and provides real-time situational awareness to support proactive discharge planning;
    - Implementation of standardized and streamlined internal escalation and *substitute decision maker* processes to support patient transitions and flow at all Central LHIN hospitals;
    - Implementation of the *Behaviour Support Transitions Resource (BSTR)* to support "upstream" identification, planning and stabilization of patients in a hospital setting;
    - *Outpatient Stroke/Neurological Rehabilitation* program at Southlake Regional Health Centre to provide allied health services in the community to Central LHIN patients recovering from a mild to moderate stroke;
    - Implementation of the *Rehabilitative Care Alliance (RCA) Definitions Framework* for Bedded and Community-Based Levels of Rehabilitative Care;

- Development and implementation of the *Integrated Care Coordinator* role that allows patients to interact with consistent staff throughout their stay, minimize handoffs, and provide a more proactive approach to discharge planning;
- Development and implementation of a *standardized ALC definition* to capture accurate data to support consistency and accuracy across all Central LHIN hospitals to strategically plan and improve critical areas within their systems to improve ALC and patient access.

- Central LHIN led a comprehensive review of Specialized Geriatric Services with providers, subject matter experts and regional LTCHs to improve equity of access to specialized care. As a result, a new team delivery model was developed aligned with sub-region design that will work to create better linkages with specialized geriatric teams and minimize avoidable transfers to hospitals.
- Additional resources were provided to strengthen the Central LHIN Behavioural Supports Ontario (BSO) initiatives. To better meet the needs of seniors with responsive and complex behaviours associated with dementia, mental health, substance use and/or other neurological conditions, staff was increased in six LTCHs and in mobile behavioural outreach teams to support patients and families in their own homes.
- To improve the quality of care for residents in LTCHs, two full-time attending nurse practitioners were funded to provide daily onsite primary care as the most responsible provider to residents of two LTCHs in Central LHIN. This initiative helps to prevent health deterioration and unnecessary visits to hospitals by addressing challenges related to limited access to primary care and rising levels of care complexity.
- Telehomecare has emerged as a client-centred approach to deliver efficient and effective care to people with chronic diseases such as Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). In 2016-17, work continued to adapt the Telehomecare program to support clients in congregate settings like Assisted Living buildings.
- Southlake Regional Health Centre has established Stroke Care Unit 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 supports the delivery of targeted and timely clinical interventions for frail seniors to prevent deconditioning, and to build strength, mobility and functional ability. In 2016-17, this program included enhanced rehabilitative service delivery in the hospital, a custom in-home rehabilitation program through the Central CCAC, and an outpatient exercise program to support functional maintenance and prevent deconditioning. In addition, this program provided education to Central LHIN hospitals on the foundational elements required to support implementation of the Assess and Restore program in a hospital setting.

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 value for money. By strengthening home and community care, 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	2017-18		2018-19		2019-20	
	Status	%	Status	%	Status	%
Based on the Long-Term Care (LTC) Capacity Plan, develop and implement community-based alternatives to traditional institutional LTC for seniors.	In progress	20	In progress	20	In progress	20
Continue to develop, implement and evaluate sustainable improvement strategies that enhance system capacity for patients waiting for Alternate Levels of Care (ALC) 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 that prevent functional decline for frail elderly patients.	Completed	100				
Strengthen the alignment between Specialized Geriatric Services and LTC Homes within sub-region planning areas to improve resident care through stronger coordination and access to service delivery.	In progress	40	Completed	10		
Continue to develop and formalize the Central LHIN Dementia and Caregiver Support Strategy.	In progress	50	Completed	50		

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 2017-18; and percentage of ALC days (LHIN MLAA target: 9.46 per cent) by end of the 2017-18.
- Reduction in ED visits for both Assisted Living clients and LTCH residents.

- Reduction in transition to LTCHs of Enhanced Assisted Living clients (based on baseline calculated from 2015-2016 Assisted Living clients).
- Targeted number of LTCHs with access to ConnectingOntario achieved.
- Dementia and Caregiver Support Strategy completed.

What are the risks/barriers to successful implementation?

- Ability to identify appropriate locations (e.g. seniors buildings, retirement homes) to introduce the Multi Unit Residential Building (MURB) alternative to LTCHs.
- Lack of specialized health human resources available to successfully implement programs.

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

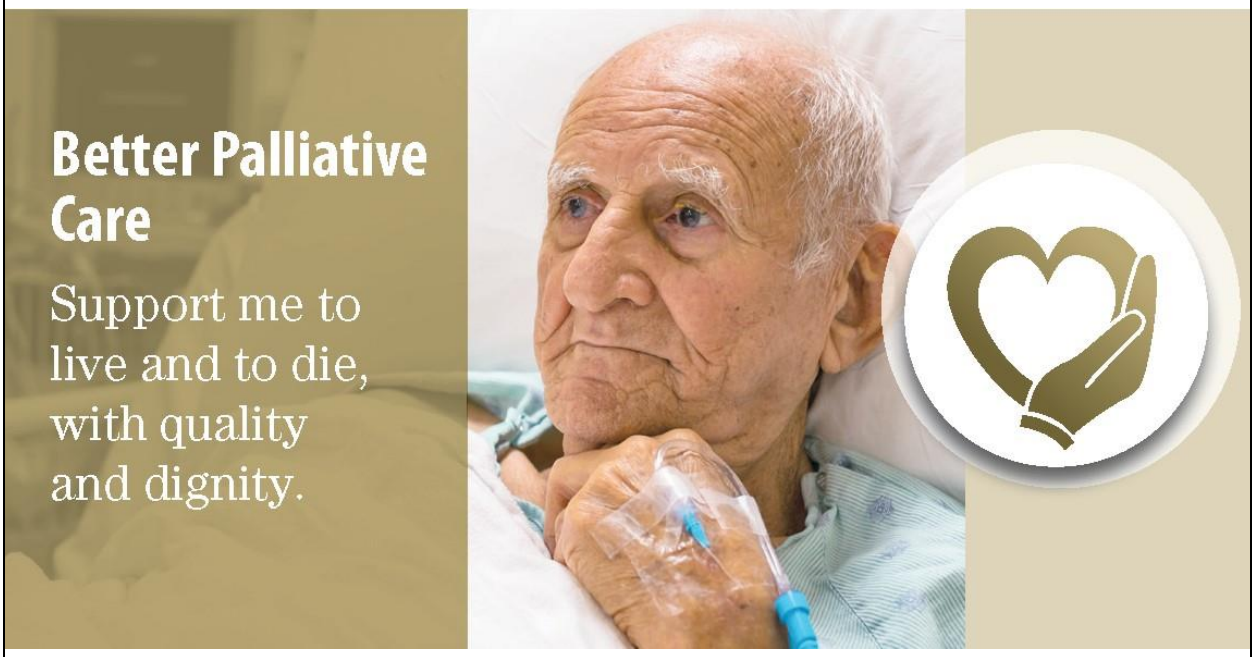
- Continue to engage with municipalities and retirement homes to understand implicit barriers to MURB service provision.
- Work with Health Service Providers and Health Force Ontario to provide adequate notice for appropriate recruitment plans and tactics.

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

- Leverage provincial electronic tools that foster coordinated care including access to clinical data repositories like ConnectingOntario for LTCHs.
- Continue to leverage remote monitoring technology in congregate settings like LTCHs and Assisted Living to improve access to care, keep patients in their home settings and prevent hospital visit(s) where appropriate.

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 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. Hospice Palliative Care (HPC) Teams for Central LHIN, based out of Southlake Regional Health Centre, has a team of eight clinical nurse consultants providing 24/7 palliative pain and symptom management consultation services. In 2015-16 the HPC Teams received 1,386 referrals, and provided 21,350 consultations.
- In addition to the HPC Team at Southlake, Central funds five other Community Support Service providers for visiting hospice and palliative education services.
- Currently, there are two residential hospices operating seven palliative care beds in Central LHIN along with new capacity becoming available over the next two years. The Margaret Bahen Hospice for York Region is a new 10-bed residential facility currently under construction and scheduled to open in late 2017. In addition, Matthews House Hospice will be expanding from four to 10 beds in 2018 along with the new Vaughan Residential Hospice preparing for opening in 2019.

Key Issues:

- Central LHIN hospitals treat about 4,000 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).*
- Among the approximately 54,000 palliative care patients who died in Ontario, only 12.7 per cent started palliative care in their second-last month of life and 47.9 per cent in their last month of life *(Source: Institute for Clinical Evaluative Sciences, 2014-15).*
- 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).*
- 70.5 per cent of palliative care patients in the Central LHIN died in hospital, the fourth highest rate among all LHINs *(Source: Health Quality Ontario, Palliative Care at the End of Life Report, 2016).*
- 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).*
- Only 55.6 per cent of caregivers for patients who received palliative care and died in residential hospices in Ontario indicated that they "knew where the patient wanted to die." *(Source: 2014-15 Caregiver Voice Survey).*
- On June 17, 2016, the federal government passed Bill C-14 which outlined requirements that patients must meet to be eligible to receive medical assistance in dying, and established safeguards that a doctor or nurse practitioner must follow to legally provide medical assistance in dying *(Source: MOHLTC website: health.gov.on.ca/en/pro/programs/maid/).*

Successes:

- In 2016-17, Central LHIN funded the operation of six new beds at Mathews House Hospice, expanded services at Hill House Hospice and received confirmation for 10 new beds for the upcoming opening of the Vaughan Hospice.
- Better Living Health and Community Services was announced as the lead operator for the new Margaret Bahen Hospice for York Region that included a full organizational integration with PalCare Network for York Region.
- In collaboration with the Central CCAC and partner organizations, Central LHIN established new centralized services to improve the coordination and access to palliative support. These include a new patient registry designed to provide early identification for patients in need of information and support, new centralized access to residential hospice beds as well as improved coordination of service through a single telephone number managed by the Central CCAC.
- An online directory of palliative care and end-of-life resources are available at *centralhealthline.ca*.
- To provide urgent palliative support during the last stages of life, the Central LHIN led the development, and 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. This project was presented at several conferences in 2016-17 and shared with other LHINs with potential to expand the phone line across the province.

- The Central LHIN's Hospice Palliative Care Teams at Southlake Regional Health Centre received funding to establish standardized palliative education across our region for physicians, health care professionals, palliative care providers, and volunteers that is based on best practice. In 2015-16, 1,674 Health Service Providers received training. Since 2015, 3,469 Health Service Providers have participated in training. *(Source: HPC Teams)*
- An implementation plan was developed that included: specialist support to primary care practitioners for pain and symptom management; medical management and interventions; care coordination with linkages to education, hospice, grief and bereavement through a single point of access. It is expected that this work will align to the needs at a sub-region level and will include support for HSPs and their capacity to deliver palliative care services.
- Central LHIN began development of a plan to enhance capacity in LTC Homes through education and training. Implementation of the plan along with dissemination of best practices for Palliative Care in LTC Homes will begin in 2017.
- The Central LHIN established the Regional Palliative Care Network in alignment with the recommendations of the Ontario Palliative Care Network (OPCN). The Network will provide guidance in building on the Central LHIN Hospice Palliative Care Action Plan to develop a comprehensive strategy aligned with identified provincial initiatives.
- LHIN staff worked with Better Living Health and Community Services and funded them to upgrade their clinical information system (CIS) and implement that system at six visiting hospices in the LHIN. This will enable better electronic patient documentation and integration with provincial Digital Health solutions including ConnectingOntario and the Integrated Assessment Record (IAR) for better patient care.

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 system navigation 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: Specialists will provide support and education to primary care providers to support their patients through their end-of-life journey.

Goal 6: Patients and caregivers will contribute to on-going quality improvement and health service design and planning through enhanced opportunities to provide feedback.

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	2017-18		2018-19		2019-20	
	Status	%	Status	%	Status	%
Continue to implement the Central LHIN Palliative Care Action Plan in alignment with sub-region planning through our Regional Palliative Care Network.	In progress	50	In progress	40	Completed	10
Develop a comprehensive Palliative Care Strategy for Central LHIN that incorporates community need within a broader spectrum of palliative and end of life care.	In progress	25	Completed	75		
Continue to operationalize Ministry-approved residential hospices.	In progress	20	In progress	60	Completed	20

How will we measure success?

- Comprehensive Palliative Care Strategy for Central LHIN completed.
- Margaret Bahen Hospice opened and operational.
- Sites and operators for remaining hospices bed allocations are in place.
- HPC Teams are using Telemedicine to support their roles as educators and clinicians.

Baseline performance and targets are established based on Ontario Palliative Care Network Indicators:

- Percentage of Central LHIN decedents who visited the ER in the last two weeks of life.
- Percentage of palliative care patients discharged home from hospital with the discharge status "home with support".
- Percentage of palliative care patients discharged from hospital who were readmitted within 30 days.
- Percentage of palliative care patients discharged from hospital who were seen in the ER within 30 days.

What are the risks/barriers to successful implementation?

- Change management regarding the acceptance of new models of care and adoption of technology.
- External factors which could significantly delay or curtail the implementation of residential hospice beds, e.g. funding procurement or construction delays.

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

- Continued comprehensive and effective engagement of Health Service Providers, stakeholders, Primary Care and patients and families.

- Continue to leverage the perspective of families and caregivers on the Regional Palliative Care Network and the LHIN's Citizens' Health Advisory Panel to maintain the focus on the patient.
- Communicate effectively with residential hospice providers (current and planned) to anticipate and mitigate risks where possible.

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 Telemedicine (two-way videoconferencing) between Hospice Palliative Care teams, Clinical Nurse Consultants, and Long-Term Care Homes.
- Leverage provincial electronic solutions including Coordinated Care Tool (CCT) technology to improve care coordination and communication between the members of the circle of care.
- Continue to build strong partnerships between service provider organizations, clinicians, physicians and care coordinators across a variety of end-of-life care settings.

Additional Comments

- The new Central LHIN Regional Palliative Care Network, established in early 2016, is guided by and aligned with the Ontario Palliative Care Network (OPCN).

Better Care for Kids and Youth

Integrated Health Services Priority

IHSP Priority Description

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

Current Status

Scope of Services, Providers and Clients Served:

- Central LHIN funds an innovative congregate care model in partnership with the March of Dimes 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 in 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.
- The new congregate care model for young adults with medical and developmental complexities will be evaluated in 2016-17, with a final report due April 2017.

Key Issues:

- Youth and young adults with medical complexities, who are unable to manage their own care, often have extensive family caregiver 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).*
- As at February 2017, five young adults were living in Long-Term-Care Homes, and two young adults with medical complexities were waiting in hospital for placement *(Source: Central CCAC).*

- Based on the analysis of December 2013 CCAC data, a cross-sector GTA LHIN 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 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.
- The model was presented at the April 2016 *Team Days* for Ministry of Community and Social Services, and at the Ontario Community Support Services Association Conference in October 2016.
- Central CCAC's "Home for the Holidays" provided over 8,300 hours of home care to over 200 children and families to allow children with complex needs to be able to stay home over Christmas and March Break.

Goals

Goal 1: Improved access to care models for young adults with medical and/or developmental complexities.

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	2017-18		2018-19		2019-20	
	Status	%	Status	%	Status	%
Review 2017 evaluation of the Cross Sector Complex Care Model and investigate expansion.	In progress	50%	Completed	50%		
Evaluate regional respite care options for young adults (18+) with medically complex care needs.	In progress	50%	Completed	50%		

How will we measure success?

- Decrease in the number of young adults with medical and developmental complexities being cared for in Long-Term Care Homes.
- Cross Sector Complex Care Model Evaluation reviewed and plan for expansion options completed.
- Regional respite care options investigated and plan for next steps completed.

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.
- Transitioning from an existing care environment to new congregate care model may be challenging for families who may not be as familiar with congregate living and therefore timing of placement may take longer than anticipated.

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 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 two Community Health Centres (CHCs) and 31 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 2015-16, 2,638 people received assisted living services, 21,293 people received CCAC personal support services and 4,348 people had 379,486 meals delivered to them *(Source: MOHLTC Healthcare Indicator Tool, Dec 2016).*
  - Central LHIN provides LHIN supported transportation to medical appointments and other LHIN funded programs such as adult day programs. In 2015-2016, close to 225,000 rides were provided to over 11,500 clients. The LHIN recently implemented a new model for transportation services to increase access and enable a seamless system from a client perspective *(Source: 2015-2016 Q4 Community Quarterly SRI Report).*
  - Our two CHCs provided services to over 11,500 people, focusing on health promotion, chronic disease management, and providing primary care to a culturally diverse population *(Source: MOHLTC Healthcare Indicator Tool, December 2016).*

- Central CCAC provided care and services to 86,000 unique clients in 2015-16 and supported 38,666 clients on any given day *(Source: MOHLTC Healthcare Indicator Tool, December 2016; Central CCAC 2015-2016 Annual Report).*

- In 2015-16, 21,462 individuals received nursing visits through CCAC and 13,937 received physiotherapy treatment in their home or school *(Source: MOHLTC Healthcare Indicator Tool, December 2016).*
- 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 physicians and specialists *(Source: 2016-2019 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 (CHF) clinics.

Key Issues:

- Prior to 2017-18, Central LHIN residents on average received lower levels of home care when compared to residents in other LHINs.[1] In 2017/18, Central LHIN received $5.9M in additional funding to address equity in home care services. This weighted population per-capita based funding was given to just four LHINs as the LHINs and province work towards consistency in levels of care to ensure resident needs are met.
- 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 *(Source: Bring Care Home Report, 2015).* In 2015-16, 75 per cent of home and community care clients had high or very high needs compared to 44 per cent in 2010-11 *(Source: Central CCAC based on RAI scores, February 2017).*
- 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: 2016-2019 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 10 Ontarians receiving home care services also rely on family caregivers; on average the ratio of professional caregiver 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 2010 and 2015, from 21 per cent to 35 per cent *(Source: HQO Annual Measuring Up Report, 2016).*

[1] *Source: Roadmap to Strengthen Home and Community Care Home Care Investment ELT Meeting Presentation Deck July 5, 2016 Average Hours of personal support provided per week, by CCAC; and Ministry of Health and Long-Term Care Health Data Branch Healthcare Indicator Tool Community Care Access Centres Global Indicators Cost per Individuals Served*

- 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.
- 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).*
- People living with Acquired Brain Injury (ABI) and physical disabilities have difficulty accessing service due to long wait lists and service pressures. Top service demands include outreach services, supportive housing, behavioural supports and caregiver support *(Source: ABI Service Priorities in the Central LHIN, CABIC August 2016, CASAS Report, 2015).*
- Approximately 10 per cent of primary care physicians are practicing in a team-based model of care *(Source: Primary Care Models within Central LHIN, ICES, 2016).*
- Throughout 2017-2018 Central LHIN will continue to implementation of *Patients First: A Roadmap to Strengthen Home and Community Care.*

Successes:

- The final two Health Links in North York West and Southeast York Region have been launched, and are providing collaborative care for high needs patients; all five Health Links are aligned with sub-regions.
- Central LHIN provided additional growth funding for our regional community-based transportation service for seniors, iRIDE^{Plus}.
- In the Central LHIN, 94 per cent of adults are attached to a primary care provider *(Source: Health Care Experience Survey, 2016).* In January 2017, Central LHIN implemented the Policy Guideline for CCAC and CSS Agency Collaborative Home and Community-Based Care Coordination, and the Policy Guideline Related to the Delivery of Personal Support Services by CCAC and CSS Agencies.
- In October 2016, Central LHIN approved funding for the development of a three-year Acquired Brain Injury and Attendance Outreach strategy to reduce lengthy wait lists. In response to the lack of social housing stock, Central LHIN made an additional investment into Mobile Attendant Outreach Services (a leading provincial best practice) which are designed to deliver attendant outreach services in-home without the reliance of a supportive housing environment.
- In November 2016, Central LHIN funded an expansion of Acquired Brain Injury Services that included Personal Support and Independence Training, Adult Day Programming and Psychology. It is anticipated that this funding will decrease wait times, improve system capacity, decrease inappropriate living situations and improve quality of life for clients and their families.

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	**2017-2018**		**2018-2019**		**2019-2020**	
	Status	%	Status	%	Status	%
Partner with primary care providers and specialists to improve patient connectivity and access to care within the six sub-regions in Central LHIN.	In progress	20	In progress	40	In progress	40
Strengthen community based collaborative care through sub-region initiatives to improve the continuity of care for patients, clients and caregivers receiving services in Central LHIN.	In progress	33	In progress	50	In progress	10
Begin implementation of Central LHIN's three year strategy to reduce wait lists and service pressures for Acquired Brain Injury (ABI) and Attendant Outreach services.	In progress	33	In progress	33	Completed	34
Continue to improve consistency and equity in service provision for home care clients.	In progress	33	In progress	33	In progress	34

How will we measure success?

- Implementation of sub-region planning approach to improving patient transitions
- MAPLe performance for home care service levels will move closer to 50th percentile performance.

- Increase in the percentage of acute care patients who have had a follow-up with a physician within seven days of discharge (MLAA monitoring indicator).
- Decrease in rate of emergency visits for conditions best managed elsewhere per 1,000 population (MLAA monitoring indicator).
- Decrease in hospitalization rate for ambulatory care sensitive conditions per 100,000 population (MLAA monitoring indicator).
- Increased adoption of eVisits (Telemedicine) by 20 per cent.
- Increased adoption of Electronic Medical Records (EMRs) in primary care.
- Implementation of eConsult between primary care and specialists as per delivery partner schedule.
- Implementation of eNotification at additional Central LHIN hospitals as per delivery partner schedule.
- Increased adoption of Hospital Report Manager (HRM) in primary care. Achieve target as per Central LHIN Digital Health plan.
- Increased adoption of Ontario Laboratories Information System (OLIS) in primary care. Achieve target as per Central LHIN Digital Health plan.
- Increased number of CSS Health Service Providers uploading assessments to the Integrated Assessment Record (IAR). Achieve target as per Central LHIN Digital Health plan.
- Remaining Central LHIN hospitals will go live with contributing data to ConnectingOntario, and target number of additional agencies will have viewer access as per delivery partner schedule.

What are the risks/barriers to successful implementation?

- Willingness and capacity of multiple stakeholder to mobilize change in a short period of time.
- Availability for the implementation of integrated technology infrastructure to be implemented in a timely way to support exchange of patient information across providers.
- Varying levels of physician willingness to participate in planning and engagement activities

What is the plan to mitigate risk?

- Active and early engagement of all leading stakeholders as sub-region approach and implementation plan is designed.
- A focused, target-based Digital Health plan that focuses on adoption of key technology solutions to support the exchange of information across providers.
- Continuous support of and engagement with primary care providers.

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

- Comprehensive and meaningful engagement with stakeholders.
- Jointly designed implementation plans with clearly outlined goals, timelines and accountabilities.
- Sub-region technology and connectivity profiles of Health Service Providers to understand current state of Digital Health readiness.

- Improving adoption of EMRs in primary care. In November 2016, OntarioMD estimates that Central LHIN has up to 450 family physicians that do not have certified EMRs and/or are not using their EMR to connect to provincial electronic tools. Improving EMR adoption will enable greater adoption of provincial electronic tools that foster coordinated care including:
  - ConnectingOntario
  - eConsult (primary care to specialist)
  - Referral Management (including primary care to specialist)
  - Hospital Report Manager (HRM)
  - eNotification
  - Ontario Laboratory Information System (OLIS)

- Telemedicine-enabled models of care such as eVisits.
- Improving adoption of the Integrated Assessment Record in the community sector so that providers in the circle of care have access to a consented client's assessment information.

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 within populations (Indigenous and Francophone) where there are recurring patterns of chronic, acute and/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 Indigenous people, representing 0.5 per cent of the population *(Source: 2016-2019 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 on-reserve community. The majority of our LHINs Indigenous community members live 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).* Indigenous people have a greater burden of illness than the general population which is exacerbated by systemic barriers to equitable health system access.
- Addiction Services for York Region is funded to provide Indigenous Cultural Competency Training to 180 Health Service Provider staff. The training is in partnership with the Ontario Federation of Indigenous Friendship Centres (OFIFC), and offers six training sessions throughout the year.
- In October 2016, the Ministry of Health and Long-Term Care announced that it would provide funding for Health Service Providers to complete Ontario Indigenous Cultural Safety core online training. In November, Central LHIN was allocated 273 online training seats for Indigenous Cultural Safety Training for Health Service Providers.

- In Central LHIN, 1.9 per cent of the population identified as Francophone, according to the provincial inclusive definition of Francophone (*Source: Inclusive Definition of Francophone (IDF), 2011 Census IDF by Health Analytics Branch, MOHLTC).*
- The Francophone community is largely composed of newcomers to Canada and most represented in the North York West sub-region and in York Region
- Two hospitals as well as home and community care services have been identified as agencies providing French Language Services (FLS) in Central LHIN.
- The City of Markham will be a designated French area under the French Language Services Act (FLSA) by July 2018.

Key Issues:

- Central LHIN's diverse communities each have unique needs and challenges that must be considered when planning.
- Central LHIN is a fast growing and diverse community; home to 820,580 newcomers, 49 per cent of the population for which English is not their first language *(Source: 2016-2019 IHSP Pan-LHIN Environmental Scan, MOHLTC, June 2015).*
- As our population ages, the incidence of chronic disease is rising. 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).*
- 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: 2016-2019 IHSP Pan-LHIN Environmental Scan, MOHLTC, June 2015).*
- In Central LHIN, approximately 39 per cent or 56,000 diabetics have not been screened for retinopathy, a leading cause of blindness in diabetics. (*Source: Data from ICES Project No. 2015 0900 645 000 in response to an MOHLTC Applied Health Research Request*).
- The increase in the number of our residents over the age of 65 with one or more chronic conditions, will continue to challenge all aspects of the health care system.

Successes:

- In 2016-17, 489 HSP staff (including mental health and addictions, CCAC, and Diabetes Education Programs) participated in Indigenous Cultural Competency and Safety Training.
- In October 2016, Central LHIN provided funding for a two-day Wellbriety Gathering hosted on Georgina Island, which brought community members together to celebrate their wellness journey and share traditional teachings with each other.
- In February 2016, Central LHIN worked with Health Service Providers to pilot an Indigenous Navigator program to support the Indigenous community to better understand and navigate the system. Central LHIN staff are working with both on and off-reserve leaders to adjust this pilot program through a co-designed format that is culturally appropriate and provides safe services for improved health outcomes.
- In partnership with Entité 4, Central LHIN adopted the Joint Action Plan for 2016-17. The objective of the plan is to improve access to French Language Services, in priority areas of: seniors care, mental health and addictions, primary care and clients with chronic conditions. One example of a targeted initiative included the delivery of chronic disease self-management workshops in French.

- Implementation of a French Language Services navigator to increase access to primary care services in French in the North York West area.
- Creation of a new Chronic Disease Prevention and Management (CDPM) Service Coordination Committee to oversee the development of an integrated regional/sub regional model that will achieve equitable access to CDPM programs across the region.
- North York General Hospital's Centre of Complex Diabetes Care and Diabetes Education Centre were awarded the 2016 Diabetes Standards Recognition Program standing by the Canadian Diabetes Association.
- In spring 2017, Black Creek Community Health Centre in partnership with Vaughan Community Health Centre and other community providers launched a new Teleopthamology Program focused on mobile retinopathy screening for people with diabetes.

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.

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	2017-18		2018-19		2019-20	
	Status	%	Status	%	Status	%
Continue to work with Public Health Units and explore opportunities to collaborate on joint priorities at neighbourhood, sub-regional and regional levels.	In progress	33	In progress	33	In progress	34
Continue to identify, support and coordinate services for priority neighbourhoods within LHIN sub-regions (e.g. North York West) that address gaps in equity and access to care.	In progress	20	In progress	40	In progress	40
Develop a comprehensive sub-region based strategy for delivering coordinated and accessible Chronic Disease Prevention and Management programs.	In progress	25	In progress	50	In progress	25

Continue to co-design and support solutions for improved access to culturally appropriate services with Central LHIN urban indigenous communities and those residing on Georgina Island.	In progress	20	In progress	40	In progress	40
In collaboration with Entité 4, Central East LHIN, Toronto Central LHIN and Central LHIN, leverage current resources to implement the Mental Health and Addictions access pathway for Francophone services.	In progress	50	Complete	50		

How will we measure success?

- Sub-region based strategy for delivering Chronic Disease Prevention and Management developed.
- Teleopthamology program has screened 432 diabetic patients for retinopathy in 2017-18.
- Increased number of health service agencies identified to offer French Language Services.
- Plan to be developed in partnership with Indigenous communities that identifies service needs to improve health outcomes for Indigenous communities.

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 Indigenous population presents challenges that may impact on the ability to implement strategies to address the needs in this population.
- Potential resources and service delivery changes required to implement new CDPM model.

What is the plan to mitigate risk?

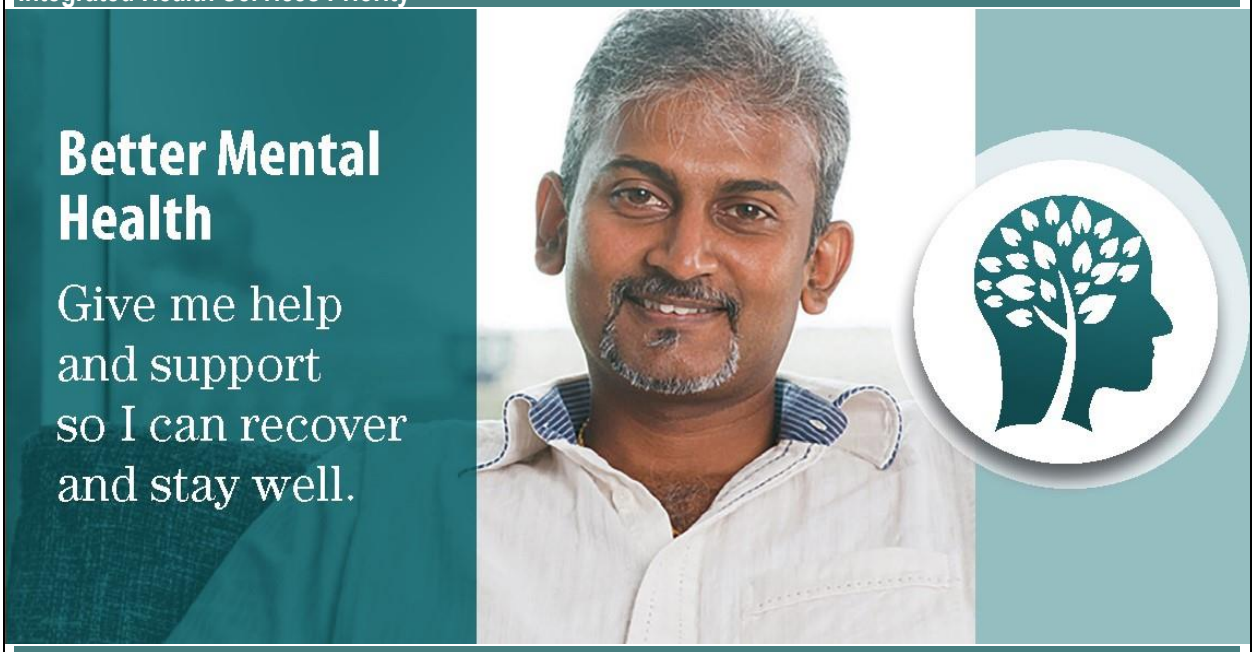
- Continue to engage Francophone communities through the collaboration with Entité 4.
- Continue to partner with Indigenous communities and strengthen relationships with HSPs providing services to Central LHIN Indigenous patients and families.
- Prioritize areas of focus with CDPM providers to develop a shared CDPM plan for implementation across sub-regions.

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).
- Continued use and adoption of the LHIN-wide Telehomecare program for remote monitoring and self-management of chronic diseases. Continue to implement and increase the use of Teleopthamology across LHIN sub-regions to improve the percentage of diabetic patients who are screened for retinopathy.

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 2015-16, there were 21,014 unscheduled emergency department visits for Central LHIN residents where the presenting issue was a mental health or substance use condition *(Source:IntelliHealth Ambulatory Visits, extracted December 2016).*
- Within Central LHIN hospitals, there are 182 inpatient adult mental health beds and 21 inpatient child/adolescent mental health beds *(Source: Daily Census 2016-2017 Q2*). 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 *(Source: 2016-2019 IHSP Pan-LHIN Environmental Scan 5.5 Mental Health (2015), 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 *(Source: 2016-2019 IHSP Pan-LHIN Environmental Scan, 5.5 Mental Health (2015), 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 community agencies served over 43,200 individuals in 2015-16 *(Source: MOHLTC HIT tool, December 2016).*

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: 2016-2019 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. zero days) were greater than the medians for Ontario. *(Source: 2016-2019 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: 2016-2019 IHSP Pan-LHIN Environmental Scan, MOHLTC, June 2015).*
- Limited access to and awareness of services and supports for caregivers. This includes crisis support for ailing family members to minimize caregiver burnout.
- 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*).
- 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, MOHLTC, 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 Supplementary Analysis, November 2016*).

Successes:

- In 2016-17, 12 additional housing units were funded through the Transitional Rehabilitation Housing Program (TRHP) for eligible forensic clients.
- In Q1 2016-17, Central LHIN had the third lowest percentage of (18.2 per cent) of repeat unscheduled emergency department visit rates within 30 days for substance abuse conditions in the province (*Source: MLAA PI Supp-MH and SA, November 2016*).
- Effectively incorporating input from people with lived experience into Central LHIN planning activities such as the Mobile Crisis Co-Responder Team, Palliative Care working groups, and the Mental Health and Addictions Service Coordination Council in York Region.
- In 2016, our community agency partners created a "One Stop Shop Directory" for mental health, addictions, and housing service resources in York Region simplifying the navigation process for both the community and providers.

- In 2016, the Central LHIN established the Mental Health and Addictions Rapid Response Table York Region to address individuals with acutely elevated levels of risk through a collaborative, integrated multi-agency approach.
- All six Central LHIN hospitals have implemented a mental health and addictions bed registry, used to identify and share capacity for mental health/addictions inpatient beds.
- York Regional Police, York Region Emergency Medical Services, and York Support Services Network have implemented a new model of onsite mobile crisis response for York Region which is under evaluation.
- In 2016, Toronto North Support Services began implementing mental health and addictions outreach activities to the Francophone community.

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 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	2017-18		2018-19		2019-20	
	Status	%	Status	%	Status	%
Evaluate the impact and efficiency of mobile crisis co-responder models for possible expansion throughout Central LHIN.	Completed	100				
Partner with stakeholders to develop a three-year Addictions Strategy aligned with the provincial Opioid Strategy.	Completed	100				
Integrate access to mental health and addiction services throughout the Central LHIN with a focus on waitlist management, prioritization and standardized eligibility criteria.	In progress	50	Completed	50		

How will we measure success?

- Reduction in repeat unscheduled emergency visits within 30 days for mental health conditions (LHIN MLAA target: 16.3 per cent).

- Reduction in repeat unscheduled emergency visits within 30 days for substance abuse conditions (LHIN MLAA target: 24.3 per cent).
- Evaluation of different mobile crisis co-responder models is complete and a standardized model implemented.
- Evaluation of key initiatives of the Mental Health and Addictions Action Plan and Service Coordination Council for York Region completed.
- Addictions Strategy has been developed and implementation plan created.
- Number of Mental Health and Addictions Health Service Providers uploading assessments to the Integrated Assessment Record (IAR) will increase. Achieve target as per Central LHIN Digital Health plan.

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 impacted stakeholders, including clients and families early and throughout the change design and implementation process.

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 waitlist to better understand service capacity and gaps.
- Use of technology (e.g. Telemedicine, Telehomecare) to enhance access to mental health and addictions services such as psychiatry, counseling and case management.
- Improving adoption of the Integrated Assessment Record in the mental health and addictions sector so that providers in the circle of care have access to a consented client's assessment information.

5. LHIN Operations and Staffing

Table A: LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2016/17 Forecast	2017/18 Planned Expenses	2018/19 Planned Expenses	2019/20 Planned Expenses
Salaries and Wages	3,426,228	3,396,890	3,396,890	3,396,890
Employee Benefits				
HOOPP	323,779	305,720	305,720	305,720
Other Benefits	395,729	373,658	373,658	373,658
Total Employee Benefits	**719,508**	**679,378**	**679,378**	**679,378**
Transportation and Communication				
Staff Travel	10,000	9,500	9,500	9,500
Governance Travel	5,000	5,000	5,000	5,000
Communications	32,294	22,750	22,750	22,750
Other	62,500	46,500	46,500	46,500
Total Transportation and Communication	**112,794**	**83,750**	**83,750**	**83,750**
Services				
Accommodation	288,293	320,508	320,508	320,508
Advertising	25,000	15,000	15,000	15,000
Consulting and Professional Services	71,200	53,200	53,200	53,200
Governance Per Diems	85,000	90,000	90,000	90,000
LSSO Shared Costs*	364,702	0	0	0
Other Meeting Expenses	34,300	34,300	34,300	34,300
Other Governance Costs	10,000	43,500	43,500	43,500
Printing & Translation	55,695	55,500	55,500	55,500
Staff Development	46,000	46,350	46,350	46,350
Total Services	**980,190**	**658,358**	**658,358**	**658,358**
Supplies and Equipment				
IT Equipment	25,000	8,000	8,000	8,000
Office Supplies & Purchased Equipment	33,112	41,292	41,292	41,292
Total Supplies and Equipment	**58,112**	**49,292**	**49,292**	**49,292**
LHIN Operations: Total Planned Expense	5,296,832	4,867,668	4,867,668	4,867,668
Total CCAC Expense		332,397,597	332,397,597	332,397,597
Total LHIN and CCAC planned Expense		337,265,265	337,265,265	337,265,265
Annual Funding Target	5,296,832	337,265,265	337,265,265	337,265,265
Variance	0	0	0	0

ABP includes all base funded programs, and excludes Physician Lead, Patient's First and ETI funding.

**As of March 1, 2017, the LHIN Operations Spending Plan reflects the transfer of LHIN Shared Services Office and LHIN Collaborative funding to Health Shared Services Ontario.*

Table B: LHIN Staffing Plan (Full-Time Equivalents)

Position Title	2016/17 Forecast FTEs	2017/18 Forecast FTEs	2018/19 Forecast FTEs	2019/20 Forecast FTEs
CEO	1.0	1.0	1.0	1.0
Senior Director	2.0	2.0	2.0	2.0
Director	4.8	4.6	4.6	4.6
Communications Manager	1.0	1.0	1.0	1.0
Communications Specialist	1.0	1.0	1.0	1.0
Corporate Controller	0.2	0.0	0.0	0.0
Corporate Governance Lead	1.3	1.0	1.0	1.0
Executive Assistant	1.0	1.0	1.0	1.0
Administrative Assistant	0.9	1.0	1.0	1.0
Senior Business Analyst	2.0	2.0	2.0	2.0
Human Resource Coordinator	1.0	1.0	1.0	1.0
Senior Coordinator	2.0	2.0	2.0	2.0
Planner	0.9	1.0	1.0	1.0
Senior Decision Support Analyst	1.0	1.0	1.0	1.0
Decision Support Analyst	0.3	0.0	0.0	0.0
Manager, Decision Support	0.6	1.0	1.0	1.0
Senior Planner	3.6	4.0	4.0	4.0
Financial Analyst	1.2	1.0	1.0	1.0
Business Analyst	2.0	2.0	2.0	2.0

Position Title	2016/17 Forecast FTEs	2017/18 Forecast FTEs	2018/19 Forecast FTEs	2019/20 Forecast FTEs
Advisory Business Analyst	1.0	1.0	1.0	1.0
Quality and Integration, Senior Lead	0.9	1.0	1.0	1.0
Program Manager	0.4	0.25	0.25	0.25
Senior Business Associate	0.7	1.0	1.0	1.0
Consultant, FLS	1.0	1.0	1.0	1.0
Total LHIN Operations FTEs	**31.7**	**31.85**	**31.85**	**31.85**
Total CCAC FTEs		**755.5**	**755.5**	**755.5**
Total LHIN and CCAC FTEs	**31.7**	**787.35**	**787.35**	**787.35**

6. Integrated Communications Strategy

Integrated Communication Strategy

Business Objectives

Central LHIN is advancing our vision to create ***Caring Communities, Healthier People*** by focusing on the six key priorities included in our Integrated Health Service Plan (IHSP) for 2016-2019.

Our business objectives for 2017-18 will be supported through an integrated communications strategy.

The Communications Team will support the business goals during the second year of the IHSP implementation, and will continue to work closely with the Ministry of Health and Long-Term Care (MOHLTC), our Health Service Providers (HSPs) and other stakeholders to play a key role in the ongoing evolution of our health care system.

Listening to the Patient Voice continues as a Core Value of the Central LHIN, and we will maintain a relentless focus on integrating the voices of the patient and family into our initiatives.

Local Messaging

- The Central LHIN collaborates and engages with our
- HSPs and system partners to invest over $2 billion in better health care for the 1.9 million people who live in our region – the largest LHIN population in the province, and one of the fastest growing.
- Through engagement, system-wide measurement, accountability agreements and targeted solutions, the Central LHIN shapes and delivers a more accessible and integrated health care system that adds value for patients through continuous improvement.
- By focusing on 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 improving the health care experience and providing better system-wide health for patients.
- Our Core Value of *Listen to the Patient Voice* continues to shape our work as we engage with patients and families, listening and learning from areas of excellence to better understand the gaps that require improvement.

Introduction of Patients First

- The *Patients First: Action Plan for Health Care* is Ontario's plan to transform the health care system into one that puts the needs of patients at its centre.
- The *Patients First: Action Plan for Health Care* sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre of our health care system, by improving the health care experience: increasing access, connecting services, informing patients and

protecting our health care system. We have made progress in all four priority areas, but we can do more to put patients first.

- By putting patients first in everything we do, we will provide faster access to the care patients need today and make the necessary investments to ensure our health system will be there for patients for generations to come.
- On December 7, 2016, Ontario passed the *Patients First Act, 2016*, an important step forward in the *Patients First Action Plan for Health Care*.
- Once fully implemented, changes supported by the *Patients First Act* will make health care more responsive to local needs as:
    - Patients will benefit from improved access to primary care, including a single number to call when they need health information or advice on where to find a new family doctor or nurse practitioner.
    - Primary care providers, inter-professional health care teams, hospitals, public health units and home and community care providers will be better able to communicate and share information, to ensure a smoother patient experience and transitions. Our goal is that patients will only have to tell their story once.
    - Administration of the health care system will be streamlined and reduced, with savings put back into improving patient care.
    - The voices of patients and families in their own health care planning will be strengthened.
    - There will be an increased focus on cultural sensitivity and the delivery of health care services to Indigenous peoples and French speaking people in Ontario.
    - LHINs will ensure that any changes are seamless and that they simplify and improve patient experience.

Communication Objectives

- Support the *Patients First* transition and transfer so that patient care remains seamless and uninterrupted
- Continue to raise awareness of programs and services available in the Central LHIN region and support patients, families and caregivers in accessing health and community services
- Increase health literacy to enable and support Ontarians to live healthy lives and manage their illnesses better.
- Engage patients, caregivers, providers, stakeholders and system leaders to become active participants in and ambassadors for transformation.

Provincial and Local Context

Context

As Ontario's health care system enters a time of unprecedented transformation, the LHINs are working with the CCACs to prepare for an expanded role. With the passage of the *Patients First Act, 2016,* the key priority is to prepare for a seamless transition and transfer of the CCAC's functions to the LHIN, and to maintain patient care delivery without disruption.

The LHINs are further guided by a mandate letter from the Ministry of Health and Long-Term Care that reinforces the *Patients First Action Plan* to deliver integrated and comprehensive health services across primary and specialist care, home and community care, hospitals, and other health care settings.

The evolution of the sub-region planning construct will be a key communication opportunity for the Central LHIN. Sub-regions will be further advanced by working with HSPs to co-design a more integrated care delivery model to strengthen the patient experience.

Audiences

Internal:

- Central LHIN Board of Directors
- Central LHIN Employees

External:

- Patients, families and caregivers
- Health Service Providers
- Primary Care Providers
- MPPs
- Non-funded partners
- Municipalities
- Media
- Thought leaders and influencers within Central LHIN

Strategic Approach

To support our business and communication objectives, the Central LHIN communications strategy will continue to:

- Leverage opportunities to position the Central LHIN as a catalyst for local health system transformation
- Leverage ongoing community relations activities to raise awareness of programs and services available in the Central LHIN region and support patients, families and caregivers in accessing health and community services
- Seek out initiatives to demonstrate how the Central LHIN:
    - Adds system-wide value
    - Aligns local solutions to provincial priorities
    - Supports, mobilizes and engages Health Service Providers, system partners and other key stakeholders to improve the health care system
- Manage and respond to ongoing issues with efficiency, 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 to respond to the various audiences:

Internal:

Central LHIN Board of Directors

- Board-to-Board communication and engagement with HSPs through Governance Council
- Website postings of Board Meeting agendas and materials
- Patient stories at Board Meetings to reinforce our Core Value of *Listen to the Patient Voice*

Central LHIN Employees

- Monthly staff meeting
- Weekly CEO voice mail blast
- Staff emails and 'huddles' as required
- LH*IN* the News - weekly update to staff on external news/events/issues
- SharePoint (intranet), including new sections for *Patients First* and learning about Central CCAC

External:

Patients, families and caregivers

- Continued opportunities to engage and to learn from patients and families, and to use their experiences in shaping local health care transformation
- Website
- Reliance on the Citizens' Health Advisory Panel to evaluate and act as a 'test market' for new communication initiatives
- Targeted communication strategies in partnership with HSPs - i.e. palliative care, holiday planning

Health Service Providers

- Chair, Board of Director and CEO meetings with HSP Boards
- CEO outreach and speaking engagements at key events/milestones
- Other meetings or events
- E-newsletter
- Communication 'blasts' to provide Ministry & LHIN updates and share HSP news & successes

Primary Care Providers

- Outreach and engagements
- LHIN-supported communications, as required

Members of Provincial Parliament with constituents in the Central LHIN

- Chair, Board of Director and CEO in-person or phone meetings with MPP
- Email updates

- LH*IN*fo Minutes

Non-funded partners, municipalities, public health, thought leaders and influencers

- Meetings
- Events and/or speaking engagements
- E-newsletter

Media

- News releases
- Backgrounders
- Issues responses

All

- IHSP
- Annual Business Plan
- Annual Report
- Website postings
- *Caring Communities, Healthier People* e-newsletter
- CEO Blog
- Twitter feed
- Other publications, as required

Evaluation

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

- Periodic staff feedback
- Insights from external engagements
- Uptake of key messages in local media
- Feedback from MPPs
- Patient comments/complaints/feedback
- Questions and comments from the Central LHIN email account
- Website and social media analytics

7. Community Engagement

Community Engagement

In accordance with the LHIN Community Engagement Guidelines (June 2016) and in keeping with the expectations and accountability of the *Local Health System Integration Act, 2006* (LHSIA), all LHINs are 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 ABP for 2017-2018. Engagement is a dynamic process and this plan will change and evolve as new opportunities and priorities emerge throughout the year.

Engagement Strategies and Leading Best Practices

Central LHIN utilizes various best practice strategies to achieve the desired outcomes and identify the appropriate levels of engagement to be applied. The Community Engagement goals and objectives will be identified in advance for priority initiatives and projects and will range across the following continuum of engagement strategies.

***Inform and Educate*:** Provide accurate, timely, relevant and easy to understand information to the community. This level of information provides information about the LHIN, while offering opportunities for community members to further understand the problems, alternatives, and/or solutions. There is no potential to influence the final outcome given this is one-way communication.

***Gather Input*:** To obtain feedback on analysis, and proposed changes. This level of engagement provides opportunities for community to voice their opinions, express their concerns, and identify potential areas for change and modifications. There may be potential opportunity to influence the final outcome.

Consult: To actively seek and receive the views of community stakeholders on policies, programs or services that affect them directly or in which they may have a significant interest. This level of engagement provides opportunities for dialogue between community and the LHIN. Consultation may result in changes to the final outcome.

Involve: To work directly with community stakeholders to ensure that their issues and concerns are continually understood and considered, enabling residents and communities to have their voices heard and to communicate their own issues. In this level, community stakeholders may provide direct advice as this is a two-way communications process. This level will influence the final outcome.

Collaborate: To work with and enable community stakeholders to work through options analysis and potential solutions to find a common purpose or agreement.

Empower: Delegated stakeholder decision making whereby final decision making authority, leading to action is assigned to a committee or other organized body.

Priority Planning Partners & Stakeholders

The Central LHIN will continue to leverage the expertise, knowledge and system experience that currently resides within the Central LHIN community of stakeholders to achieve its goals and objectives.

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 essential partners to enable us to make better decisions together.

Central LHIN stakeholders include:

- **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;
- **Public Health Units** (York Region Public Health Services, Toronto Public Health, Simcoe Muskoka District Health Unit);
- **Municipalities** including the Region of York, City of Toronto and County of Simco**e** (for example, participation through the Community Partnership Council Meeting in the Region of York for their Newcomers initiative);
- **Primary Care Providers** (physicians, nurse practitioners, community health centres, all physician group practice types);
- **Community Support and Mental Health and Addictions service agencies;**
- **Home and Community Care providers;**
- **Long-Term Care Homes and Retirement Residences;**
- **Hospitals;**
- **Indigenous people living in urban, rural and on-reserve communities;**
- **Francophone communities through the partnership with Entité 4;**
- **Other Local Health Integration Networks;**
- **Academic Institutions;**
- **Ministry of Health and Long-Term Care;**
- **Ministry of Child and Youth Services;**
- **Ministry of Community and Social Services.**

Working Groups/Committees/Councils

Many of our stakeholders are invited to participate in Central LHIN committees with the goal to gather input, consult and collaborate in planning activities and decisions. Central LHIN committees in operation for 2017-18 are as follows:

- **Central LHIN Patient and Family Advisory Council, formerly** established in 2013 as the Citizens Health Advisory Panel, 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.
- **Integrated Care Advisory Council (ICAC)** was established in January 2017 to advise on the development of a consistent approach to sub-region engagement and planning. Membership is representative of leadership across sectors and stakeholders.
- **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 and Emergency Services. This group meets bi-monthly with a mandate of planning, implementing, and evaluating performance measures to improve the delivery of emergency services in the Central LHIN hospitals, and to collaborate and exchange best practices.
- **Critical Care Network** is a working group that includes administrative and clinical leads from each Central LHIN hospital, CritiCall Ontario and Central LHIN staff. It is co-chaired by the Central LHIN Critical Care Physician Lead and the Central LHIN Director of Strategic Initiatives. The group meets bi-monthly and holds additional meetings as required for the purpose of planning, implementing, and evaluating performance measures to improve the delivery of Critical Care Services in Central LHIN hospitals.
- **Regional Palliative Care Network –** The Central LHIN has established the Central LHIN Regional Palliative Care Network to advise the LHIN and provide leadership and structure to facilitate the development of a comprehensive, integrated and coordinated system of hospice palliative care. Furthermore, the Network oversees the implementation of the Central LHIN Palliative Care Action Plan through a regional approach that addresses priorities and needs in the Central LHIN area.
- **Digital Health Advisory Council –** Central LHIN's Integrated Health Service Plan 2016-2019 identifies digital health as a key enabler for achieving the Ministry's priorities and those of the LHIN and its partners. The Council is composed 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 Digital Health Strategic Plan for each year as indicated in the Ministry-LHIN Accountability Agreement (MLAA) and provide guidance and advice on digital health 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, the Canadian Mental Health Association-York Region 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 continue moving forward with coordinated mental health and addiction services in the Central LHIN.

- **Mental Health Hub Committee** – was established in 2016 with a focus on improving timely access to high quality crisis services in the right place, while alleviating pressures faced by hospital emergency departments and first responders. The committee has representation from federal and provincial Members of Parliament, regional police and emergency medical services, as well as service providers across the health sector.
- **Chronic Disease Prevention and Management Service Coordination Committee (CDPMSCC) –** established in 2016 is comprised of York Region Public Health, people with lived experience, health service providers and primary care. The purpose of this group is to provide advice to the Central LHIN on the coordination and integration of service delivery at the local level and 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.
- **Alternate Level of Care (ALC) Collaborative –** The ALC Collaborative is a dedicated team comprised of Central LHIN hospitals, 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 continue to actively engage with Hospitals, community and other system partners as appropriate throughout its two year funding period (December 2015 to December 2017).
- **Central LHIN Eye Care Committee (ECC) –** The Central LHIN ECC is an advisory body comprised of Central LHIN staff and administrative/medical leads from each Central LHIN hospital. The committee meets quarterly to provide advice on best practices for the overall service provision, coordination, delivery, evaluation and evolution of the eye care service models in Central LHIN hospitals. The committee also provides advice on the implementation of the Central LHIN vision care strategy, human resource planning, clinical utilization, and management of quality of care pertaining to eye care services across the Central LHIN.
- **Quality Based Procedures (QBP) Steering Committee** - Implementation of QBPs is an integral component of the Health System Funding Reform (HSFR), aimed to incentivize health care providers to adopt best practices to that result in improved patient outcomes in a cost-effective manner. With

representatives from Central LHIN, all Central LHIN hospitals, the QBP Steering Committee provides guidance, identify support needs and monitor QBP implementation across Central LHIN.

- **Stroke Planning and Care Council (SPCC)** – The Central LHIN SPCC is a forum to bring stakeholders together for collaborative planning, input and advice on service integration opportunities and performance gaps and support achievement of targeted performance metrics. Working in alignment with the Ontario Stroke Network's vision and mission, the SPCC provides guidance to the Central LHIN and other stakeholders in stroke care, supporting them to achieve current best practices for stroke care.
- **Clinical Services Vice President (VP) Planning Group** – The Clinical Services VP Planning Group consists of clinically-focused senior leaders from Central LHIN hospitals to provide specific support to maintain major clinical program/service plans and to ensure patient access to new innovations and expertise. This group makes recommendations using a system-wide planning approach and explores opportunities to scale and spread better practices that can be supported through evidence and data.
- **Long-Term Care Sector Working Group (LTCWG) –** The mandate of the LTCWG includes supporting the Central LHIN IHSP priorities and 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 the long-term care sector specific issues and support knowledge building and exchange.

Sub-region Engagement and System Transformation

With the passage of the *Patients First Act, 2016,* and the Ministry's approval of Central LHINs six sub-regions in December 2016, Central LHIN staff are advancing consultations on our sub-region planning strategy, which includes working with HSPs to co-design a more integrated care delivery model to strengthen the patient experience.

In January 2017, the Central LHIN formed an Integrated Care Advisory Council (ICAC) to begin the process of developing an approach to working together to implement sub-region based planning. Central LHIN is focused on strengthening care for patients through the establishment of consistent, quality-based outcomes. The ICAC is an advisory group, composed of informed and highly engaged system leaders tasked with challenging the way we plan and design the system to build a strengthened lens on patient care and experience.

Central LHIN is committed to achieving a common agenda through a co-design approach to achieving consistent, quality-based outcomes that improve and strengthen patient care. Implementation will be aligned with the directions and priorities as set out it the Minister's Mandate Letter.

The sub-region strategy in the Central LHIN is grounded in the Collective Impact methodology, providing a platform for stakeholders to work together towards a specific common goal to solve complex challenges.

The Collective Impact approach will support stakeholders to:

- Transform the patient experience
- Drive innovation and sustainable service delivery
- Build and foster interdependent networks of care

- Tackle health inequities by focusing on population health

Recognizing that sub-region development involves all of the partners in the Central LHIN across the continuum of care, engagement will commence with the launch of community conversations that will set the stage for developing a consistent approach involving all six sub-region, and allowing for customization at the local level. Community conversations will inform the development of an engagement strategy to support co-design at the sub-region level, including the broader development of a LHIN-wide approach to sub-region implementation.

Through continued engagement Central LHIN will build health system partner capability to generate innovative ideas, build implementation plans through new and existing partnerships, and measure success against performance system level indicators. Collaboration with system partners is key to the success of our system transformation. Engagement across the continuum will also provide an opportunity to enable technology and information management which are key elements for empowering the voice of the patient, connecting the various sectors of the health care system and enabling patients to access services through enhanced technology utilization.

2017-18 Engagement Activities

Stakeholder Group	**Purpose**	**Engagement Goals**	**Format**	**Frequency**
Urban Indigenous Community: NinOskKomTin	To co-design services and supports required for Indigenous communities	Co-create a plan that is aligned with the needs of the community and improves access to culturally appropriate services	In-person meetings involving elders and members of the community	Throughout the year
Chippewas of Georgina Island	To co-design of services and supports required for Indigenous communities	Co-create a plan that is aligned with the needs of the community and improves access to culturally appropriate services	In-person meetings involving the Health Services office of Georgina Island	Throughout the year
Sub-region Planning Tables	To engage and co-create sustainable solutions for gaps in patient care transitions at the sub-region level	Identify 2-3 LHIN-wide solutions to improve care transitions for patients, families and caregivers	Multiple. May include in-person meetings; interactive webinars; OTN; surveys	Throughout the year

Primary Care – Family Physicians	To obtain meaningful physician input into relevant system decisions, and to work towards locally sustainable solutions to provide high quality primary care services	To help align both primary care physician activities and objectives with LHIN priorities	In-person; work groups; interactive forums	Throughout the year
Primary Care – Specialists	To engage specialists in dialogue to further support and implement referral initiatives including eConsult	To improve timely access to specialist care and support patient transitions across the care continuum	In-person; work groups; interactive forums	Throughout the year
Primary Care – Nurse Practitioners	To engage primary care nurse practitioners in relevant system design and subsequent integration to provide high quality primary care services	To further align and strengthen primary care at the sub-region level	In-person; interactive forums	Throughout the year
Mental Health and Addictions Service Coordination Council	To improve the integration, coordination and distribution of mental health and addictions services for transitional aged youth and adults in York Region	To facilitate and support the implementation of the Mental Health and Addictions Supports within Housing Action Plan for York Region	In-person meetings	Bimonthly (6x per year)
Mental Health and Addictions Providers & People with Lived Experience	To bring providers and people with lived experience together to develop a Central LHIN Addictions Strategy	The development of a three-year Central LHIN Addictions Strategy that will align with the provincial Opioid Strategy to enhance addictions supports and harm reduction	Group workshop; key informant interviews	Bimonthly, Spring/Summer 2017
Regional Palliative Care Network	To provide leadership and structure to facilitate the development of a comprehensive, integrated and coordinated system of hospice palliative care	Develop a comprehensive strategy for Palliative Care that is aligned with sub-region planning and	In-person meetings; webinars; teleconference; learning forums	Quarterly

		timely access to care		
Emergency Department Working Group	To bring all six Central LHIN Emergency Departments together for planning, implementing, and exchanging best practices	Advance the ED/ALC strategy and consult on sub-region transition planning	In-person meetings with webinar and teleconference access	Bi-monthly
Health Links Partnership Table	To bring together Health Links leads, home and community care, digital health, hosting organizations and other stakeholders together to revisit 2015 value stream analysis (VSA)	Update the value stream analysis for Health Links to determine consistent approach across all sites	Large, facilitated event to revisit VSA. Subsequent report back meetings to validate and refine approach	Revisiting of VSA planned for late spring/early summer Validation and refinement for final model through to end of year
Sub-region Learning Forum	To bring all six sub-region planning tables together to share a Learning Forum in preparation for implementation	Provide opportunity for sub-regions leaders to share what is and is not working	Large, facilitated event	Fall 2017
ALC Collaborative	To support the development and implementation of LHIN-wide strategies to enhance patient flow from acute to community settings	Implement and evaluate sustainable strategies that enhance system capacity and patient flow across the care continuum	Regular in-person meetings that may include other hospital and community stakeholders	Ongoing
Community Support Services – Programs, Services for Seniors	Based on the LTC Capacity Plan, develop and implement community-based alternatives to traditional institutional LTC for Seniors	Recommendations for the expansion and enhancement of Adult Day Programs for Seniors	In-person meetings with webinar and teleconference access	Monthly
Community Support Services – ABI and Attendant Outreach Services	To review three-year strategy to reduce wait lists and service pressures for Acquired Brain Injury (ABI) and Attendant Outreach services	Recommendations for the implementation of the three-year strategy	In-person meetings with webinar and teleconference access	Monthly
Community Support	To develop and formalize the Central LHIN	Recommendations for future investments in	In-person meetings with webinar and	Monthly

Services – Seniors Services	dementia and caregiver support strategy	respite and other caregiver supports	teleconference access	
Community Support Services – Erin Oak Kids	To explore respite options for families with medically/developmentally complex young adults	Recommendations for future respite investments	In-person meetings with webinar and teleconference access	Bimonthly
Clinical Services VP Planning Group	To engage all Central LHIN hospitals to guide the development of clinical strategies to advance care	Consult and provide guidance in advancing the ALC strategy, sub regional planning to improve care transitions for patients, families and caregivers	In-person meetings with webinar and teleconference access	Bimonthly
QBP Steering Committee – Quality Based Procedures	To bring together Central LHIN hospitals to support and provide guidance on the implementation of QBPs	Consult and provide guidance on transition plans at the sub regional level, particularly those related to the pertinent QBPs	In-person meetings with webinar and teleconference access	Quarterly
Stroke Planning and Care Council	To bring together stakeholders in stroke care to collaboratively plan and support the spread of best practices for stroke care	Provide opportunity for stroke care stakeholders to give input on transition plans at the sub regional level	In-person meetings with webinar and teleconference access	Quarterly
North York West French Language Services Advisory Committee	To bring together health care providers and community stakeholders to discuss the needs of the Francophone community in the North York West sub-region	Promote health services in French (i.e. primary care, chronic illnesses, seniors care and mental health) to improve service delivery and health outcomes	In-person meetings with teleconference access	Quarterly
French Language Health Planning - Entité 4	To plan, coordinate and integrate high quality health care services for Francophones in Central LHIN communities	To improve equitable access to health services for the local Francophone population	In-person meetings with teleconference access	Throughout the year

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