Annual Business Plan: 2012/13

Toronto Central LHIN

June 2012

1) **CONTEXT**
    - **Transmittal Letter**
    - **Mandate**
    - **Overview of Agency's Current and Forthcoming Programs and Services**
    - **Assessment of Issues Facing Agency**

2) **CORE CONTENT**
    - **Implementation Plan**
    - **Performance Measures and Targets**
    - **Proposed operation expenditures, projected revenues, funding requirements**
    - **Resources needed to meet goals and objectives**
    - **Initiatives involved third parties**
    - **Risk assessment and management**

3) **LHIN STAFFING AND OPERATIONS**
    - **Summary of staff numbers; impact of business plan on human resources; compensation strategy**
    - **Proposed capital expenditures**

4) **COMMUNICATIONS PLAN**
    - **Details of community engagement specific to this Annual Business Plan (ABP)**

5) **LSSO and LHINC SUBMISSIONS**

1. Context

1.1. Transmittal Letter

Toronto Central **LHIN**

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June 13, 2012

Rachel Kampus
Assistant Deputy Minister
Ministry of Health and Long Term Care
Health System Accountability and Performance Division
80 Grosvenor Street
5th Floor, Hepburn Block
Toronto ON M7A 1R3

Dear Ms. Kampus,

Re: Toronto Central Local Health Integration Network – Final Annual Business Plan, 2012/13

In accordance with the requirements of the Local Health System Integration Act 2006, I am pleased to present you with the Toronto Central LHIN's (TC LHIN) Annual Business Plan (ABP) for 2012/13. This plan outlines how the TC LHIN will operationalize and deliver on the final years' priorities of the 2010-2013 Integrated Health Service Plan (IHSP-2). The TC LHIN remains focused on delivering on current priorities while it strives for system transformation.

The ABP sets out a focused set of action steps designed to achieve the TC LHIN's IHSP-2 priorities: emergency room wait times and alternate level of care days, diabetes, mental health and additions and value and affordability.

We look forward to continuing to collaborate with the MOHLTC, other LHINs and health service providers and communities in the TC LHIN to deliver on the ABP to improve health care for the people that we serve.

Sincerely,

Angela Ferrante
Board Chair

Ontario
Local Health Integration Network

1.2. Mandate and Strategic Directions

The Toronto Central LHIN's (TC LHIN's) long-term vision is shared by all 14 LHINs of a health care system that all Ontarians can count on regardless of their individual circumstances and where they live. It envisions-*A health care system that helps people stay healthy, delivers good care when people need it, and will be there for our children and grandchildren.*

1.3. Overview of current and forthcoming programs / activities

The TC LHIN has the highest concentration of health services in Canada, with 172 Health Service Providers (HSP), many of which provide more than one service. The TC LHIN's size is reflected in its base transfer payments budget of $4.3 billion provided by the Ministry of Health & Long-Term Care (MOHLTC).

With this budget, TC LHIN is responsible for funding:

- 17 hospitals with a total of 2.16 million patient days
- 17 community health centers (CHCs) providing an estimated 332,100 primary care Face-to-Face Encounters
- 67 agencies providing community support services (CSS) totaling an estimated 656,700 visits and 857,300 resident days
- 68 agencies that provide mental health, addictions & problem gambling (MHA) services totaling an estimated 1,406,900 visits
- 1 community care access centre (CCAC) providing estimated 3,404,400 visits/hours of care and case coordination
- 37 long-term care (LTC) homes accounting for almost 5,966 long-term care beds (equivalent to 2,177,600 days)

By the numbers: TC LHIN Health Service Providers (HSPs)

Table 1: Health Service Providers in Toronto Central LHIN, 2011/12			
Health Service Providers	**# of LHIN Funded Programs**	**Ministry of Health and Long-Term Care Base Funding ***	**% of Total Base Budget of the TC LHIN**
Community Care Access Centres (CCACs)	1	$ 196,208,851	4.60%
Community Health Centres (CHCs)	17	$ 79,180,123	1.86%
Mental Health: Addictions, Supportive Housing, Community Mental Health	68	$ 117,403,459	2.76%
Community Support Services (CSS) including Acquired Brain Injury, Assisted Living in Supportiv Housing	67	$ 87,494,766	2.06%
Long-Term Care (LTC) Homes	37	$ 236,935,092	5.57%
Hospitals	17	$ 3,539,569,071	83.15%
TOTAL	**207^**	**$ 4,256,791,362**	**100%**

*Only inclusive of base funding transfer payments in 10-11 (includes accruals)

^Some Health Service Providers provide more than one service (e.g. Baycrest Centre for Geriatric Care is both a hospital and a long term care facility); accordingly, there are 172 Health Service Provider entities representing 207 health service providers.

Structural Integrations:

The following structural integrations have been finalized. These will reduce the total number HSPs without reducing the services provided.

- York Community Services Centre and New Heights Community Health Centre into Unison Health & Community Services; 2010-11
- Sunnybrook Health Sciences Centre and St. John's Rehabilitation Hospital; 2011-12
- University Health Network and Toronto Rehabilitation Institute; 2011-12
- WoodGreen Community Services and Community Care East York; 2011-12

1.4. Assessment of issues facing the agency

- ***LTC home capacity*** – One of the main contributors to ALC is head-to-place patients – many of whom are long-stay ALC (in hospital >40 days). It is particularly challenging to place certain patients; i.e., behavioural issues given the 99% LTC occupancy rate in the TC LHIN.

- ***High inflow of patients from other LHINs -*** Due to the specialized services offered within TC LHIN, a high number of patients from outside the TC LHIN boundaries come to the LHIN for services that are not available in their LHIN of residence. 40% of ALC patients in TC LHIN hospitals reside in other LHINs. Also some patients coming to the TC LHIN for secondary and quaternary specialized acute care are not recurring home for follow-up care. At the same time, a significant number of patients from outside the LHIN come to the TC LHIN for services that are available close to home. While TC LHIN specialized services are there for patients from across Ontario and patient choice is important, the flow of people into the LHIN contributes to budget pressures, ALC rates and challenges regarding patient flow.

- ***Inflationary pressures and balanced budget challenges -*** In spite of the Ontario government's constraint on public sector wages, independent arbitrators have awarded wage increases (2% over 2 years). This trend could have a very significant impact on health service providers' funding for clinical and other health care programs

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- ***Physical Infrastructure renovations required for many community agencies -*** Many community agencies are housed in old buildings which require renovations or are having to relocate and renegotiate leases. New leases are typically at a much higher rate and could involve leasehold improvements. The Ministry has a relatively small allocation to cover capital costs in the community.

- ***Significant changes to 2011-12 interprovincial inpatient & outpatient per diem rates -*** Out-of-province inter-provincial inpatient per diem rates have changed in the 2011/12 fiscal year, which is expected to have a significant financial impact on the academic centers. For example, Sick Kids Hospital noted that the net impact of the rate changes will be a reduction in out-of-provide revenues of approximately $750,000, year over year (calculated based on 2010-11 volumes) which will impact its ability to deliver care for Ontario patients. Adult academic centres are experiencing similar economic impacts.

- ***Community capacity to support ALC reduction -*** TC LHIN is undertaking significant efforts to transfer ALC patients from hospitals to more appropriate destinations in the community. Community services and support agencies need stronger capacity to meet the needs of an increasing number of clients with complex health issues. Without adequate funding to build community capacity, ALC reduction efforts will be eventually limited and current initiatives may not be sustainable.

- ***Long Term Care Home (LTCH) redevelopment in TCLHIN -*** In TC LHIN, 19 of the 36 LTCHs require redevelopment. These facilities will be challenged to do this redevelopment given their existing capacity and capital infrastructure. For example:

  • The high land costs that may be required to relocate or expand the existing site.

  • Land-locked, little or no land available for redevelopment at many sites

  • Facilities that redevelop with existing footprint will likely need to reduce capacity to meet new standards – impacting on revenue, optimal operational economies of scale and system-level capacity

  • Decanting and interim operational challenges (additional operating costs, potential staffing difficulties etc.) associated with redevelopment

  During the last LTCH redevelopment project, Toronto lost over 1,000 beds because many facilities chose to redevelop outside of TC LHIN because of the constraints and challenges mentioned above. TC LHIN has among the lowest per capita LTCH beds in the province; therefore any further loss of LTCH beds would have a profound impact on TC LHIN's ER/ALC performance and patient access to the appropriate level of care.

- ***Potential City of Toronto Budget Cuts -*** There are a number of potential future budget reduction issues that the TC LHIN continues to monitor and discuss with different areas of the City. While the LHINs were successful in their request to have the TTC delay the planned service cut to Wheel-Trans for Toronto dialysis patients, the TTC plans to discontinue services to dialysis patients who do not meet the TTC's criteria for mobility. The LHINs are working with stakeholders to review the dialysis population taking Wheel-Trans to determine an accurate number of patients who require transportation services based on their health needs and the cost. City and provincial support will be critical to find a long-term solution to ensure all dialysis needing transportation receive services that meet their needs.

  The other issues that were considered in the 2011 budget and may emerge in the City's 2012 budget are: the potential closure of homeless shelters; and the sale and/or changes in the eligibility for Toronto Community Housing which, if pursued, would impact mental health and addictions and other high-needs patients requiring supportive housing. As well, future city involvement in and funding of municipal LTC homes remains a risk.

1.5. Implementation Plans

PART I: IDENTIFICATION OF INTEGRATED HEALTH SERVICE PRIORITY
Integrated Health Service Priority:
Reduce emergency room (ER) wait times and alternative level of care (ALC) days.
Integrated Health Service Plan (IHSP) Priority Description:
One of the main reasons ERs get backed up is that the hospital beds needed by ER patients are occupied by 'alternate level of care' (ALC) patients waiting to be transferred to a more appropriate care setting. The TC LHIN's strategies focused on the greatest ALC problems and root causes impeding patient flow to the most appropriate place of care. The TC LHIN is targeting problems with specific populations who experience access barriers including highly complex and hard-to-place patients. These efforts also enhance health equity. Target high-needs populations including those with mental illness and/or addictions; frail, marginalized, and at-risk seniors; those who are homeless or under-housed; those who live in poverty; and/or new immigrants. These population groups are known to make frequent and regular use of ER and inpatient hospital services.
Current Status
Scope of services In the TC LHIN, all hospitals, the CCAC and community agencies are working on initiatives that address ER waits and ALC at a system level. Initiatives underway are focused on 1. Reducing ER demand 2. Improving ER capacity and performance 3. Facilitating care in the community **Number and type of clients serviced annually** Between 2010 and 2011, TC LHIN realized an overall 6.1% increase in ER visit volumes. MOHLTC data from the Emergency Department Information System (EDIS) for the first two quarters of fiscal 2011 indicated that this trend is continuing as the TC LHIN saw a 5.8% increase in ER volumes compared to the first two quarters of fiscal 2010. This increase (11.1%) was within the population of CTAS I-III categories. The TC LHIN has seen a 4.8% decrease in the number of visits that are within CTAS IV-V categories. Analysis continues to reflect that this decrease is related to Aging at Home and other ALC reduction strategies which are reducing the population of 65+ patients in ERs.

Information from the Discharge Abstract Database (DAD) and the National Ambulatory Care Reporting System (NACRS) Q1YTD 2011 (as cited in Intellihealth) reflects that in TC LHIN, seniors 65+ represent 19.1% of ER visits and 29.9% of acute hospitalizations. In Q1 YTD 2011, 71.7%% of acute ALC discharges were for seniors.

Key issues facing this client group

The challenge in ER continues to be timely treatment of those who need to be admitted to hospital. The primary reason is challenges with the flow of discharged patients from the hospital.

Successes of the past year

Reducing ER demand: There has been a significant increase in ER visits in the CTAS I-III category (19.2%) between FY 2008/09 and 2010/11. However, the TC LHIN has seen a negligible increase in the CTAS IV-V category (0.3%) related to the above mentioned challenge with patient flow, particularly into and out of rehab and complex continuing care hospitals.

Outreach initiatives in the TC LHIN have also helped to support reductions in ER demand as well as initiatives to divert patients from the ER who could be better supported in alternative settings.

Improving ER capacity and performance: TC LHIN programs as part of ER P4R and Aging at Home as well as complementary ALC reduction strategies have contributed to a 38.5% reduction in ER wait times across all acuity levels in TC LHIN hospitals between April 2008 and April 2011.

Facilitating care in the community: Home First and similar strategies to support seniors to remain at home instead of in institutional care are transforming the patient experience for ALC patients. Since the inception of this program, there has been a 30% reduction in the number of seniors waiting in hospital for LTC – resulting in more acute beds being freed up every month helping to promote better hospital patient access and flow.

The collaborative efforts of the CCAC, hospitals, primary care and community agencies in projects such as Virtual Ward, Integrated Care for Complex Population (ICCP) and the Intensive Case Management Program targeting complex Long Stay ALC patients are ensuring clients receive appropriate levels of care, with appropriate supports and services outside of the hospital.

Of the 148 patients initially identified and reviewed to be transitioned to a more appropriate place of care, 53 ALC patients remain in hospital, representing a reduction of 64% in the long stay ALC population.

Four CEO-led task forces were brought together in 2011 to address various issues related to LS ALC clients. These four task groups included: long-term ventilation, mental health and addictions, discharge planning and rehab/complex continuing care. Two of these groups focused on transitioning specific patient populations from hospital to other settings and developing long-term strategies to address the needs of the populations while the other two identified recommendations to improve patient flow across the continuum. The recommendations are now being implemented.

More broadly, AAH investments from 2008/09 to 2010/11 directly benefited over 28,000 seniors. Many caregivers are being supported by specific Aging at Home (AAH) programs. In 2011/12 this is forecasted to increase by approximately 15,000 seniors.

Other initiatives underway which support the TC LHIN's ER ALC strategy include: 1) the local implementation of the Provincial Behavioural Supports Strategy; the TC LHIN has received endorsement of its action plan and will be moving to implementation early in 2012; 2) a recently convened Children & Adolescent initiative that will be focused on developing a cross-continuum population-specific action plan leveraging existing expertise required to support children and adolescents with complex medical needs with effective transition planning and specialized support. The plan will identify and work to address the top priority areas of focus for the TC LHIN, and will identify recommendations for action.

Building on the success of the TC LHIN's Senior Friendly Hospital Strategy, the TC LHIN is now leading the implementation of a similar provincial strategy to help enhance the care of seniors and reduce the risk of their functional and cognitive decline while in hospital. In 2011/12, 1655 hospitals completed self-assessments, the first step towards creating Senior Friend Hospital improvement plans for hospitals. It is anticipated that this will contribute to decreased lengths of stay, reduced readmission rates, and reduced costs of hospitalization; all of which will help improve hospital ALC rates.

Resource Matching and Referral (RM&R) is an electronic referral system that matches clients with the most appropriate service and is a key tool for managing wait times and ALC. This year, RM&R expanded to include over 30 community support service agencies. The TC LHIN is the lead LHIN for the provincial roll-out of RM&R that began in 2011/12.

PART II: GOALS and ACTION PLANS

Goal(s)

Initiative #1: Standardize referral and intake processes to improve the flow of patients to and within community programs.

Building on the successful implementation of RM&R to date, the TC LHIN will move to further expand and enhance the community support services for seniors system. The main focus will be on supporting clients' transition from acute, rehabilitation and CCC to community settings and transitions within community programs through facilitating agency to agency referrals. The TC LHIN will also continue to work with the MHA sector to develop a plan to subsequently expand RM&R to include services they provide.

Initiative #2: Enhance community based programs and services to support patients at home.
Building on the AAH Strategy, the TC LHIN will focus on sustaining and expanding high performing programs that have contributed to reductions in ALC and ER demand. The TC LHIN will continue to monitor the effectiveness of initiatives through well-established performance measurement mechanisms. The focus will remain on supporting at-risk groups such as frail seniors and individuals with mental illness and/or addictions to remain in the community and/or transition back to the community after a hospital stay. Early in 2012 the TC LHIN will be implementing its behavioural support plan that will result in additional community-based and long-term care home-based resources to help address the needs of seniors with severe mental illness, addictions, dementia and behavioural response issues.

The TC LHIN will also continue to work with providers and the TC CCAC to develop and implement initiatives and support strategies to address recommendations and issues identified through the assessment of the needs of long-stay ALC patients across the TC LHIN with particular emphasis on patient transition out of hospital and the preventing the generation of new long-stay ALC patients. This work will initially focus on patients requiring long-term ventilation services, those with mental health and addictions, and those currently residing in rehabilitation and CCC beds.

The TC LHIN is working to strengthen the community sector to enable health service providers to meet increased demand and greater patient complexity and to provide services in the right place of care at the most cost effective price. Building upon the important function of adult day programs, TC LHIN provided support for additional day program capacity which will specialize in serving higher acuity clients to help them remain in the community. In addition, the TC LHIN will be increasing access to homemaking services in order to support lower acuity clients living in their communities who require ongoing support with instrumental activities and daily living. The first phase of the homemaking expansion will target clients who will transition from the CCAC to the right place of care in the CSS sector.

In 2012/13 the TC LHIN will expand upon current initiatives to support caregivers of medically complex children, and high-risk frail seniors in the community.

TC LHIN is one of three LHINs involved in the telehomecare phase I implementation. The focus of the telehomecare will be to connect clients with diseases such as chronic heart disease and chronic obstructive pulmonary disease to the telehomecare program – this program will be embedded in the TC CCAC and will have strong linkages and partnerships with primary care and specialty clinics, such as heart failure clinics. The TC LHIN is part of the Ontario Telemedicine Network's pilot for portable video technology, and will test the use of this equipment, as well as standard, stand-alone video equipment, with clients in the community who are at risk of being readmitted to hospital or ED. The technology will be used to connect clients to specialists, healthcare providers, primary care, and allied health from their home (shelter, long term care home).

Initiative #3: Improve hospital processes to increase capacity in the emergency department.

The TC LHIN will work with its providers to continue to redesign hospital processes to ensure discharge planning is done in the early stage of hospital stays to help people advance to the next level of care sooner. The TC LHIN will continue to address recommendations highlighted in the Auditor General's 2011 Annual Report, section 3.02 titled "Discharge of Hospital Patients". The TC LHIN will continue to identify high-risk seniors so that they receive the appropriate services after discharge from hospital. In addition the Senior Friendly Hospital Strategy will support proper discharge process by reducing seniors' functional decline in hospital and supporting seniors' involvement in planning their post-acute care needs.

The TC LHIN will continue to leverage the unprecedented information available through iPORT and the RM&R system to sustain this effort. Through RM&R, the TC LHIN will continue to monitor referral response times, acceptance and denial rates, and will assess system demand and capacity gaps.

Consistency with Government Priorities:
The actions highlighted above contribute to the provincial priorities to address ER wait times and ALC.

Action Plans/Interventions			
Action Plans/ Interventions:	*2010-11*	*2011-12*	*2012-13*
Standardized intake in place for all senior clients of CSS agencies and engage 80% of TC LHIN organizations in the *RMR* program	30% complete	30%	40%
Put mechanisms in place to identify at-risk seniors in all acute care hospitals and subsequently expand to at-risk individuals in additional sectors	40% complete	40%	20%
Expand *Integrated Care Model* (ICM) to involve all acute care hospitals and subsequently expand to include other settings and/or populations	50% complete	50%	-
Enhance community capacity to support transition of seniors from ER/ALC	100% complete	-	-
Identify priorities for reducing risk of functional decline for seniors while in acute care and incorporate into the Hospital Service Accountability Agreements (H-SAAs)		100%	
Ongoing process redesign activities and focus on discharge planning enabling all hospitals to meet ER and ALC targets	70% complete	30%	

Expected Impacts of Key Action Items
By the end of three years, more people will be treated in the ER or admitted from the ER within the province's wait time targets. More individuals, particularly the frail elderly, people with mental illnesses and addictions, and people with complex, chronic diseases will receive timely access to an enhanced range of services. **Outcome metrics:** • Proportion of admitted patients treated within the length of stay (LOS) target of ≤ 8 hours. • Proportion of non-admitted, high acuity patients treated within their respective targets of ≤ 8 hours for Canadian Triage and Acuity Scale - CTAS I - II and ≤ 6 hours for CTAS III • Proportion of non-admitted, low acuity patients treated within the LOS target of ≤ 4 hours • Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment.

What are the risks/barriers to successful implementation?	
Risk	*Mitigation strategy*
There are significant and concurrent process and culture change initiatives underway across multiple organizations and multiple sectors.	Successful change will take time and requires leadership support across all HSPs. TC LHIN will continue to provide the leadership in prioritizing and coordinating this effort to help facilitate required changes.
All hospitals (acute, rehabilitation, CCC) in TC LHIN continue to be challenged in reducing high ALC days.	Targeted strategies will be implemented to deal with identified challenges and opportunities. These include leveraging recommendations identified through the recent Long Stay ALC review, and through leveraging RM&R and iPORT.
Impacts of activities may not show quick results in ER and ALC indicators	Close monitoring of implementation efforts and proactive risk identification will continue. Will focus on measuring performance in ways that allows gradual improvements to be identified and for progress to be assessed.
Availability of resources to support decanting of long stay ALC patients.	Work with MOHLTC and local providers to identify opportunities to address gaps and identified barriers. TC LHIN's hospital sector table brings CEOs together to address these issues as a sector.

What are some of the key enablers that would allow us to achieve our goal?
• Supporting and sustaining our ALC gains is dependent on having in place sufficient community sector capacity to support a higher volume of more complex clients. • There is a quality and patient satisfaction imperative to ensure that people receive care "as close to home" when possible and feasible from quality of care perspective. This goal is built on an assumption that providers in local communities are able to take clients returning from care settings in other jurisdictions/LHINs. • Automated systems are vital to making this goal a reality. Specifically, implementation of an ED notification system, and RM&R.

PART I: IDENTIFICATION OF INTEGRATED HEALTH SERVICE PRIORITY
Integrated Health Service Priority:
Improve the prevention, management and treatment of diabetes.
IHSP Priority Description:
In 2012/13 the TC LHIN will sustain efforts to improve health outcomes for people with diabetes by preventing them from developing other conditions such as heart disease. The TC LHIN's diabetes strategies will improve health equity by targeting groups most at risk such as visible minorities, low-income groups and marginalized populations in our communities.
Current Status
Diabetes services in TC LHIN There are currently a variety of diabetes programs available across the TC LHIN: 14 sites with MOHLTC-funded diabetes education programs, approximately 13 hospital-based diabetes education programs, as well as both diabetes education centres and clinics (most often found in hospitals or as part of family health teams). Diabetes education programs provide group classes and one-on-one individual education and counseling, as well as outreach and clinical management with medical directives, whereas, diabetes clinics are most often a one-stop-shop for a spectrum of services. The TC LHIN has four MOHLTC-funded Chronic Kidney Disease regional programs that offer home and onsite dialysis services to patients from all across Ontario. All of these programs are linked together through the coordination work of the TC LHIN Regional Diabetes Coordination Centre. While studies have shown that people with complex diabetes that see specialists have better health outcomes, the majority of people with complex diabetes in the TC LHIN are being managed by primary care practitioners. Primary Care practitioner education about diabetes management is key.

Key issues and types of clients served

It is estimated that 46% of the TC LHIN's population aged 12 and over are physically inactive and over 40% of those aged 18 and over are either overweight or obese, a key risk factor for diabetes.

Although TC LHIN has the highest physician-to-population ratio in Ontario, there is a considerable proportion of the population without regular access to a physician. Approximately 12% of people aged 12+ reported not having a regular medical doctor compared to 9% in Ontario; 19% did not have contact with medical doctors. These proportions are higher in those with lower socioeconomic status and the homeless. Only some 50% of primary care physicians in the TC LHIN are in some form of team-based comprehensive primary care model. We know primary care teams are best equipped to manage patients with multiple chronic diseases.

For diabetes, 13% of people with a primary care physician had an avoidable ER/hospital visit compared to 25% with no such primary care contact.

In addition, a considerable number of people with diabetes are not receiving the recommended standard of care e.g., the standard tests that monitor for disease progression and complications.

Successes of the past year

The TC LHIN Regional Coordination Centre (RCC), hosted by the South Riverdale CHC and launched in 2010-11, made it easier for people living with diabetes to be connected to diabetes education, support services, and secondary prevention care that are culturally appropriate. To date, the RCC has hired a primary care lead and endocrinologist, launched a website with a registry of diabetes providers, care pathways, and is supporting the adoption of best practices and integration of services across the TC LHIN. One of the key achievements of 2011/12 was the implementation of one referral form for all diabetes education programs which will kick-start the standardization of client care and data collection.

Close to 2,000 people have been identified as at-risk for having diabetes and have been linked to primary care physicians, nutritional counseling services and lifestyle management classes as a result of the three screening and outreach programs the TC LHIN funds for high-needs seniors - South Asian, Aboriginal and Caribbean populations.

PART II: GOALS and ACTION PLANS

Goal(s)

To improve the prevention, management and treatment of diabetes and reduce complications from other conditions, TC LHIN has prioritized the following initiatives:

Initiative #1: Expand outreach and screening programs, starting with high-needs neighbourhoods.

The TC LHIN will monitor the performance of the screening and outreach initiatives implemented in high-needs neighbourhoods to ensure effectiveness and enhance existing diabetes programs by facilitating linkages among screening, intervention and treatment programs.

Initiative #2: Increase access to primary care teams – including family physicians, nurse practitioners and dieticians – starting with high-needs neighbourhoods and high-risk groups.

The TC LHIN will:

1. Include the TC LHIN primary care lead(s) into the RCC steering committee
2. Oversee the implementation of a primary care engagement strategy in high-risk neighbourhoods; and

Initiative #3: Improve the quality, consistency and comprehensiveness of diabetes in the primary care or physician clinic setting.

The TC LHIN will

1. Support and complement the work of the RCC by facilitating the dissemination of best practices and innovations, and centralize client referrals and coordination of care;
2. Support the provincial effort to develop a baseline diabetes dataset based on the number of people with diabetes and physician adherence to four evidence-based tests over the past 12 months; and

As the MOHLTC is the designated lead for the diabetes strategy, the TC LHIN will act in accordance with MOHLTC direction on these initiatives.

Consistency with Government Priorities:

The TC LHIN's diabetes actions will support the implementation of the provincial strategy in TC LHIN by addressing local community needs and gaps and supporting provincial initiatives such as data on adherence to evidence-based tests.

Action Plans/Interventions			
Action Plans/ Interventions:	*2010-11*	*2011-12*	*2012-13*
Building on the success of two newly created outreach and screening programs, the TC LHIN will expand into additional high-needs neighbourhoods in the TC LHIN.	100% Complete		
Increase access to team-based care through expansion of Diabetes Education Programs beginning with high-risk neighbourhoods and populations (e.g., Aboriginals) and increase self-management supports.	50% In progress	50%	
Establish Diabetes RCC.	100% Complete		
Establish baseline diabetes dataset, set performance targets, and primary care providers begin to receive reports, starting with the Aboriginal population.	*Ministry driven initiative – dataset currently in pilot phase with test LHINs, TC LHIN expecting to participate in phase 2 or 3.*		

Expected Impacts of Key Action Items
By the end of three years, more individuals at-risk of having diabetes will • be identified and connected to appropriate supports to prevent the illness; • be receiving care according to best practices; and • have received better quality of care in a coordinated fashion. **Outcome metrics:** The TC LHIN will monitor indicators identified by the Provincial Diabetes Strategy with the guidance of the TC LHIN RCC Steering Committee.

What are the risks/ barriers to successful implementation?	
Risks	*Mitigation strategies*
Improved management of diabetes and its related complications depend heavily on primary care which is largely outside the jurisdiction of the TC LHINs.	Include comprehensive primary care engagement strategies, leveraging LHIN-MOHLTC steering committees and other bodies to achieve involvement and buy-in from the primary care community. The TC LHIN's primary care lead9s) will increase the LHIN's capacity to engagement primary care physicians and stakeholders.
In order to drive the coordination of diabetes care, the diabetes patient registry needs to be in place.	Continuing to prepare providers for the adoption of the registry: undertake an IT readiness assessment and identifying areas where the TC LHIN can help build a solid Information Management/Information Technology foundation.
Impacts of initiatives may not be fully realized in the short-term.	Close monitoring of implementation efforts and proactive risk identification will continue. Will focus on measuring performance in ways that allows gradual improvements to be identified and for progress to be assessed.
What are some of the key enablers that would allow us to achieve our goal?	
TC LHIN works closely with the TC LHIN Regional Diabetes Coordinating Centre Steering Committee which is made up of members across sectors as well as the TC LHIN participating in the annual review of the RCCs.	

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICE PRIORITY

Integrated Health Service Priority:

Improve the prevention, management and treatment of mental health and addictions (MHA)

IHSP Priority Description:

It is estimated that 1 in 5 adults will experience mental illness in their lifetime. Of these, 3% will be *seriously* affected. Some of the most marginalized people in TC LHIN are living with mental illness and/or addiction. Addressing this priority will support the TC LHIN's efforts to improve health equity by addressing barriers faced by these populations.

MHA clients account for a high proportion of avoidable ER visits, particularly those clients with severe mental health issues, concurrent disorders and behavioural issues, many of whom live in poverty are homeless or under housed.

Many people diagnosed with a mental illness and/or addictions also have other chronic conditions, such as diabetes and cardiovascular disease.

Many people with mental illness and/or addictions would be better served in alternative locations in the community sector. Integration of services for certain populations or within a geographic area will improve quality services and support better transitions between levels of care.

Current Status

Key issues and types of clients served

The TC LHIN has the highest rate in the province of repeat emergency department visits within 30 days for those with a mental illness or substance use issue. While considerable efforts have been made to understand the issues and to test solutions, the problem remains significant.

Repeat ER visits reflect system quality and access issues within health care including poor transitions from the hospital back to the community; ineffective or inappropriate care for this complex population at the ER; lack of access to health services elsewhere, and lack of alternative resources within other settings to support crises and after-hours care.

Also, the social determinants of health, such as affordable and supportive housing, income, and social inclusion, have a large impact on MHA. As of November 2011, there were more than 2000 individuals on the combined wait list for supportive mental health and substance use housing units.

MHA clients require both targeted approaches that address specific barriers faced by marginalized and other specific populations and to have services integrated across the sectors they access.

Finally, The TC LHIN continues to improve data quality through the creation of common tools for data collection, standard definitions, relevant indicators, and practical use for the data collected.

Mental Health and Addictions Services in TC LHIN

There are 68 organizations in the TC LHIN that are funded to provide mental health, addictions and problem gambling services.

Of these 46 organizations provide only mental health services including supportive housing, 11 provide addiction services only and 11 provide both mental health and addiction services.

Two of these organizations have a mandate to serve people from across the province. The TC LHIN funds seven consumer survivor initiatives (CSI) as well as a network lead to plan and coordinate CSI activities and provide input to LHIN planning activities. MHA services are fragmented and difficult to coordinate and other providers have a low awareness of the services that exist and how to access them.

Successes of the past year

TC LHIN investments are centred on foundational activities to create a better coordinated system. The focus is on coordinated, single points of access for key services.

Early investments in integrated care, e.g. Toronto Community Addictions Team (TCAT) for the most intensive and complex users of both withdrawal management services (WMS) and TC LHIN ERs have resulted in large reductions in WMS admissions (average 45% reduction after 9 months in the program) as well as significant reductions in repeat ER visits (51% for all TCAT clients in pilot phase – Jan 2010- March 31, 2011)

Based on its successful outcomes, TC LHIN invested additional resources to allow TCAT to provide service to increased numbers of repeat users of WMS and the ED. Additionally, a one-year extension was provided to further evaluate the Peer Outreach Worker Pilot; Concurrent Disorders Crisis Response and Coordinated Access to Primary Care Clinics for the Homeless (CATCH). CATCH has been a successful model to connect unattached, highly complex patients to primary and psychiatric care, as well as community supports. Between April and October 2011, 86 clients were served through the primary care clinic and more than 40 clients were provided with psychiatric supports.

The Peer Outreach Worker pilot is providing peer and navigation supports to individuals in the west end of the TC LHIN, and linking clients to primary care and other community services. From April to October 2011, 1100 client accompaniments were provided, more than 475 referrals were made to community support services and more than 250 clients were linked to primary care.

The Gerstein Centre project provides crisis supports to individuals with concurrent disorders and addictions and has served over 475 clients through telephone support/response, mobile crisis response, short-term case management, and a short-stay residence.

TC LHIN continued to support the provincial implementation of the new Addictions Supportive Housing program. To date, 200 units have been allocated to six partnerships that provide supportive housing to people with complex addictions, including capacity to service women-led families and people living with HIV/AIDS.

To continue the focus on priority populations, the TC LHIN held a second think tank focusing on the needs of seniors with mental health and addictions issues. The recommendations generated through this initiative informed the TC LHIN Behavioural Supports Strategy (see below).

In August 2011, the TC LHIN received $3.2 million from the MOHLTC for new health human resources to support the Behavioural Supports Ontario (BSO) Project. Implementation of the BSO strategy will begin in Q4 11/12.

The action plan includes the implementation of a behavioural support unit in LTC, mobile behavioural outreach supports in LTC and the community as well as an education/training component. The TC LHIN has appointed a health service provider to lead the implementation of the action plan.

TC LHIN moved into the third phase of implementation for the Ontario Common Assessment of Need (OCAN) which has been implemented in 89.5% of eligible mental health organizations. In Q4 a first phase of implementation for shared assessments is moving forward with HSPs representing all 5 GTA LHINs. Mental health and justice supportive housing along with the new stock for addictions supportive housing has integrated into a central access point for supportive housing The creation and expansion of a coordinated system for intensive case management and assertive community treatment teams for addiction services are underway. Finally, a joint cross-LHIN committee is developing an access model for the mental health and addictions services across the GTA, starting with Central and TC LHIN.

The TC LHIN MHA's expert Decision Support Working Group made recommendations for improving MHA data quality. They also recommended MHA performance and system monitoring indicators in alignment with provincial and LHIN priorities. Work is underway includes reviewing of Common Data Set-Mental Health (CDA-MH) and Ontario Healthcare Reporting System (OHRS) reporting for supportive housing agencies to facilitate standardized reporting for that sector. Data collection, analysis and reporting of the selected indicators are also underway. A working group of MHA agencies are leading the sector quality indicator work to develop a common set of quality indicators that align with TC LHIN's "big dot" system quality indicators which in turn are consistent with the province's quality indicators.

PART II: GOALS and ACTION PLANS

Goal(s)

The overarching objectives for the three years of the IHSP are to:

1. improve access to coordinated and integrated mental illness and addictions services;
2. increase capacity in areas of known need; and
3. reduce unnecessary ER visits and hospitalizations beginning with a focus in population groups with the highest needs.

To enable this effort, the TC LHIN has prioritized the following initiatives over the course of the plan:

Initiative #1: Develop and implement initiatives to target the needs of the most complex and vulnerable communities in the TC LHIN.

The TC LHIN will continue to identify integration initiatives for priority populations highlighted through the Gap Analysis project (homeless, seniors, immigrants, refugees, aboriginals, and children and youth). We will also continue to test and evaluate population-specific integrated care initiatives that build on existing investments such as the 200 new units of addictions specific supportive housing.

The TC LHIN will also work with local providers to address recommendations regarding care for long-stay ALC patients with mental illness and addictions. Finally, the TC LHIN will begin to implement the TC LHINs' Behavioural Support Strategy.

Initiative #2: Implement standardized assessment process in Community Mental Health programs.

A shared assessment model will be tested. The lessons learned from the use of OCAN within an addictions setting will be shared with provincial committee and local providers.

Initiative #3: Develop and implement standardized intake and referral process in MHA programs.

The TC LHIN will continue to evaluate and build on coordinated access projects aimed at streamlining access, building common tools, and simplifying referral processes.

Initiative #4: Enhance data collection and utilization in Mental Health and Addictions programs and services to support evidence-informed decision-making.

The TC LHIN will collect and analyze identified datasets and set baseline performance targets consisted with the provincial MHA strategy. The TC LHIN will implement recommendations to improve MHA data quality while we continue the indicator work started in 2010/11.

Consistency with Government Priorities:

The Minister's Advisory Group on the 10-Year MHA Strategy will be used to guide future strategic implementation plans.

Action Plans/Interventions			
Action Plans/ Interventions:	*2010-11*	*2011-12*	*2012-13*
Using the findings from the TC LHIN MHA Gap Analysis, develop and implement initiatives to target the needs of the most complex and vulnerable communities in the TC LHIN • ER Diversion: Evaluate outcomes from pilots and set priorities for program development, knowledge transfer and scaling • Cross sector forums focused on priority populations • Addictions Supportive Housing: Implementation • Implement Quality initiative in designated TC LHIN sites • Implement strategies to address needs of Long Stay ALC patients with mental illness and addictions	40% Target exceeded	20%	40%
Implement OCAN in the majority of community mental health agencies in TC LHIN. • Shared assessment model pilot • Reports from OCAN generated for monitoring and evaluation	50%	40%	10%
Implement common intake and referral form for MHA • Enhance Coordinated Access to Supportive Housing model by integrating other MHA supportive housing • Develop plan for coordinated access for mental health intensive case management/assertive community treatment teams in TC LHIN • Develop plan for coordinated access for Addictions Services in TC LHIN	10%	50%	40%
Enhance data collection and utilization in mental health and addictions programs and services in order to support evidence informed decision making • Set performance targets for MHA performance indicators identified. • Implement action plan to improve MHA data quality	30%	15%	55%

Expected Impacts of Key Action Items
By acting on these priorities, more people with mental health and/or addictions issues will have quicker and more equitable access to the right mix of services to meet their needs; more clients who require supportive housing services will be housed; more clients will have access to integrated, collaborative care resulting in better outcomes; and providers and the TC LHIN will have access to better quality data to support decision making. **Metrics:** The TC LHIN will measure the following MHA performance indicators: • Percentage of agencies using OCAN tool • HSP Reporting compliance indicator • Repeat ED visits for MH and Addictions within 30 days

What are the risks/barriers to successful implementation?	
Risk	*Mitigation strategy*
Stretched sector, so ability to drive change is unproven	Focus on HSPs that have high levels of readiness, willingness and proven ability to succeed.
It is difficult to coordinate a high number of disparate HSPs that serve mental illness and/or addictions clients.	Focus on discrete areas within the mental illness and addictions sector and begin implementing coordination in areas of most need.
Lack of/or poor quality data can prohibit comprehensive monitoring of impact of initiatives	Encourage HSPs to improve data reporting and ensure that all required data are identified and collected throughout the course of the projects.

What are some of the key enablers that would allow us to achieve our goal?
• All MHA projects are supported by cross-sector Advisory or Implementation Committees (e.g. TCAT, Supportive Housing for People with Problematic Substance Use, OCAN, Decision Support Working Group) which strengthen implementation leadership and enhances sustainability across the system. • GTA LHINs' support and engagement for cross-LHIN activities will reduce inconsistency or confusion across the TC LHIN boundaries. • Inter-ministerial collaboration regarding challenges such as affordable housing, income and food security. • Targeted funding opportunities to strengthen select service capacity to support continued reductions in ER visits.

PART I: IDENTIFICATION OF INTEGRATED HEALTH SERVICE PRIORITY

Integrated Health Service Priority:

Improve the value and affordability of health care services

IHSP Priority Description:

This year, and in the future, the overall level of funding for HSPs will be below historical growth. As a result, the TC LHIN is working with HSPs to pursue opportunities to deliver health care services at a lower cost while maintaining or improving quality standards. For example:

- Introducing new evidence-based models of care more efficient than current structures
- Formalizing back-office collaborations to reduce the cost of administration and support services
- Realigning existing services to ensure the most appropriate care is provided at the right place

Current Status

Key Issues

All providers must find efficiencies in the system to maintain or improve access and services. Furthermore, individual providers recognize that any funding increases will be targeted to areas of need, results and system priorities.

Successes of the past year

One risk is that HSPs may transfer patients/clients to other sectors in an effort to balance budgets; however, the systemic effects of these transfers may not be taken into account. To mitigate this, in 2011, the TC LHIN developed a process and supporting tools to ensure service changes within and across sectors were holistically planned with a patient (client)-centered approach.

Significant capacity planning was performed in 2011 to develop the future state organization of stroke and total joint replacement (TJR) best practice models of care. Recommendations were endorsed by the TC LHIN and hospital CEOs.

The Community Support Service (CSS) Agencies and the TC CCAC are working closely together to support clients who are cared for by both sectors efficiently to reduce duplication and gaps in care. To date, the CSS sector and CCAC have developed and piloted protocols, and have had several cross-sector education sessions to ensure that this work is adopted by all providers.

Summary of the Year Ahead

Value and Affordability (V&A) work in the hospital sector in 2012/13 will focus on scoping and planning initiatives to improve quality, efficiency and care pathways for the stroke and TJR populations.

V&A work in the community sector will focus on improving performance through HSP benchmarking and community capacity-building initiatives.

PART II: GOALS and ACTION PLANS

Goal(s)

TC LHIN has identified the following initiatives in 2012/13 to support the value and affordability priority:

Initiative #1: Implement Stroke and Total Joint Replacement (TJR) Flow Models

After significant planning and engagement, TC LHIN acute and rehab hospitals endorsed new models of care for stroke patients. The next step is to move towards implementation in 2012/13. Due to the complexity and implications of implementing new models of care across 12 hospitals, the TC LHIN will be working with all hospitals to phase in these changes through 2012/13.

In addition, an Implementation Task Group is building on previous work done in TJR to develop clinical and practice changes aligned to the quality indicators of the Provincial Orthopedic Quality Scorecard. In 2012/13, the TC LHIN will coordinate implementation of the Stroke Flow and TJR Flow recommendations.

This will include the development of performance targets and a monitoring and management structure.

Any resource or financial efficiencies realized through the stroke and TJR realignment will be reinvested to target areas of need.

Initiative #2: Costing of Community Based Services

In the current accountability agreements, the varied integrity of the data collected from community HSPs limited the TC LHIN's ability to use reporting to improve performance management. However, in 2012/13 there will be improved data reporting standards.

With consistent and accurate information from the HSPs, the TC LHIN will be better positioned for system-level monitoring and decision-making. At a minimum, this data will allow benchmarking for peer and/or year-over-year performance management. It will also be identify targeted investment opportunities.

Initiative #3: Review of TC LHIN transportation services and implement recommendations for improved services

The City's decision to reduce Wheel-Trans funding for dialysis patients highlighted the vulnerability of the city's health care transportation system. The community capacity-building work will include advancing greater integration within the transportation to reduce gaps in service and inefficiencies.

Consistency with Government Priorities:

The TC LHIN's V&A strategies support *Ontario Action Plan for Health Care and address* many of the findings of key provincial health reports including *Caring for Our Aging Population and Addressing Alternate Level of Care (ALC) by Dr. David Walker*, *Enhancing the Continuum of Care - Dr. G. Ross* Baker, and the *Drummond Report*.

Action Plans/Interventions			
Action Plans/ Interventions:	*2010-11*	*2011-12*	*2012-13*
Implement hospital-specific V&A Task Force business plans – stroke and TJR flow	50%	25%	25%
Costing of community based services	N/A	50%	50%
Review of TC LHIN transportation services and implement recommendations for improved services	N/A	50%	50%
Enhance data collection in the community support service and mental health and addiction agencies.	In 2011 the MOHLTC reviewed the CSS and CMHA reporting standards which we will use locally.		
Identify and support opportunities for collaboration between the hospital and LTC sector	The MOHLTC's Behavioural Supports Strategy was introduced in 2011 and became the primary focus of this objective. Please refer to the MHA section for more detail.		

Expected Impacts of Key Action Items	
• Sustainable flow of stroke and TJR patients from hospital to right place of care, including home or inpatient rehab. • Improved efficiency and utilization of TC LHIN transportation services, directly improving patient access and satisfaction, and lowering transportation costs. • Cost of services by community agencies to be benchmarked which will allow us to target future investments, and support a potential re-alignment and/or integration of services.	
What are the risks/barriers to successful implementation?	
Risk	*Mitigation strategy*
HSPs may transfer patients/clients to other sectors in an effort to balance budgets; however, the systemic effects of these transfers may not be taken into account.	Application of the TC LHIN process and tools designed specifically to mitigate this risk. Any proposed changes that fail to satisfy the principles outlined are not approved.
Stretched sectors and ability to drive change is unproven.	Select HSPs who have high levels of readiness, willingness and proven ability to succeed. Raise awareness of the urgency for change given the current economic situation.
Providers want to stop participating in shared initiatives.	Ensure that stakeholders are committed through service accountability agreements, Project Charters and Memorandums of Understanding.
Business plans do not translate to the anticipated gains.	Methodology to measure savings identified up front. Regular monitoring and evaluation to flag issues earlier and reduce the magnitude of not achieving the results.
What are some of the key enablers that would allow us to achieve our goal?	
• HSP engagement and commitment to undergo significant cultural and process changes is the key enabler. • Transparency and collaboration among HSPs within and across sectors. • TC LHIN's role in delivering a clear and consistent message towards integration will be the primary mechanism to deal with funding reductions, increased demand and quality improvement.	

1.6. Enablers

Health Equity

Health equity is a critical element of quality improvement. This is particularly crucial in socially and ethno-culturally diverse areas such as Toronto.

Health equity means that all people receiving the same standard of care regardless of where they live, their backgrounds or the language they speak.

In 2012/13, the third year of the Integrated Health Services Plan-2 (IHSP-2), the TC LHIN will focus on advancing health equity initiatives identified by local stakeholders during IHSP-2 community engagement sessions to develop the TC LHIN's Health Equity Action Plan. The TC LHIN's Health Equity Action Plan has three core strategies:

- Share and expand phone interpretation for non-English speaking people.
- Better access for populations without health insurance, starting with an agreement to streamline referrals between CHCs and hospitals.
- Equity indicators and equity data collection at the point of care.

The TC LHIN also continues to use an equity lens in planning and undertaking its work to ensure that the needs and impacts of different groups are considered.

In 2012/13 the TC LHIN's community engagement efforts will focus on targeted strategies to reach and involve individuals who lack a voice in established community engagement processes because of barriers.

Spotlight on French Language Services

The TC LHINs and many health service providers are subject to the French Language Services Act (FLSA) which requires us to provide "active offer" of French Language Services to the Francophones we serve. In addition, the Local Health Services Integration Act (LHSIA) sets out obligations for the TC LHIN to engage Francophones as part of healthy system planning and decision-making.

The French Language Health Services Planning Entities were established across the province in 2011/12. The Entity for Toronto Central, Mississauga Halton, and Central West LHINs now has a full Board, Executive Director and staff in place. The Entity and the three LHINs developed and are underway implementing a Joint Action Plan for 2011/12. The goals of the Joint Plan are to enhance the engagement of Francophones in the three LHINs, to develop current and evidence-backed information about the Francophone community's needs, service availability; and to strengthen the capacity of providers to offer health services in French.

The Entity has advised the LHINs regarding effective strategies for engaging Francophones who live in and receive care within their areas. The TC LHIN and the Entity have increased outreach with diverse community groups and specifically immigrant Francophones who face some of the greatest barriers to health care

The Entity has completed an initial current state assessment of the health care needs, services and gaps in the three LHINs.

The TC LHIN has a designated French Language Services Coordinator. In addition to our joint work with the Entity, in 2011/12 the TC LHIN focused on increasing the volume and timeliness of information to the public and stakeholders in French, building awareness of Board, staff and health services providers about FLS needs, obligations and expectations in light of the new FLS Regulations – Regulation 284/2011. The TC LHIN has been working with providers as sectors and with individual agencies to develop strategies to enhance the active offer of FLS services.

The TC LHIN will undertake the following activities in 2012/13 to meet its accountabilities and to help address the health needs of the Francophone communities we serve:

- Continue to strengthen consultation and involvement of the Francophone communities in the TC LHIN including new immigrants, seniors, LGBTQ and other high needs and under-served members of the Francophone community. Use targeted techniques to engage diverse sub-groups within the larger Francophone population
- Create targeted strategies to address service needs and gaps identified through the Entity's needs assessment work and other evidence and input from the community.
- Identify and pursue opportunities for greater integration and coordination of FLS services within the health care system.
- Identify and pursue opportunities to better understand the needs and develop patient-centred approaches to care for Francophones across the TC LHIN boundaries, particularly within the planning zone of Toronto Central, Mississauga Halton and Central West LHINs.
- Include Francophone populations in the development of health equity indicators for the TC LHIN and work with other LHINs to develop FLS indicators to incorporate into Service Accountability Agreements.

eHealth

The eHealth landscape in the TC LHIN is extremely complex. HSPs benefit from the coordination and direction provided by the TC LHIN with the support of eHealth Ontario and other partners to create an integrated and effective eHealth environment.

eHealth Ontario has provided critical support to help the TC LHIN develop the leadership, focus and infrastructure for key eHealth initiatives that will improve quality of care and efficiency including RM&R and ConnectingGTA.

Major Initiatives:

<u>Resource Matching and Referral (RM&R)</u>

RM&R is an electronic referral system that will improve client/patient transitions from one level of care to the next, and match people to the most appropriate level of care based on a standardized assessment of need(s). To date in the Toronto Central LHIN:

- Inpatient medical and surgical units in six acute care facilities are using RM&R to refer patients to LTC convalescent care, CCAC for in-home services, rehabilitation, CCC, and CSS for seniors

- Eight rehabilitation and CCC facilities are receiving referrals from acute care, and sending referrals for LTC, convalescent care, and CCAC in-home services;
- Toronto Central CCAC is using RM&R to
  - Receive referrals for LTC placement and in-home services;
  - Send referrals for LTC, convalescent care, and CSS for seniors; and
  - Manage LTC waitlists while utilizing bed-level matching functionality
- 37 LTC homes using RM&R to receive referrals from the CCAC for placement, posting bed vacancies using bed-level matching functionality
- 7 emergency departments are using RM&R to refer patients to CSS for seniors
- 34 CSS health service providers that provide services for seniors are using RM&R within their coordinated access model to receive referrals from acute care and CCAC, and send referrals amongst their partner CSS providers

Toronto Central LHIN is also the lead for the provincial Alternate Level of Care RM&R Business Transformation Initiative (ALC RM&R BTI) which aims to standardize referral processes, forms and terminology across the province for the following 4 referral pathways:

- Acute (Medical and Surgical Inpatient) sending referrals to Rehabilitation
- Acute (Medical and Surgical Inpatient) sending referrals to Complex Continuing Care (CCC)
- Acute (Medical and Surgical Inpatient) sending referrals to Long-Term Care
- Acute (Medical and Surgical Inpatient) sending referrals to CCAC In-Home Services

Toronto Central LHIN as a participant in this initiative is part of Cluster 2, which includes Central West, Mississauga Halton, Toronto Central, Central, Central East, and North Simcoe Muskoka LHINs, The Cluster will work together for ALC RM&R BTI and the subsequent design, implementation and maintenance of an RM&R program within a provincially defined framework. This approach will optimize the patient experience, address clinical needs across LHIN boundaries, and allow for an effective use of the funds available for RM&R.

The Toronto Central LHIN is leading parallel work to define a provincial solution approach for RM&R which will inform future project phases.

ConnectingGTA (cGTA)

cGTA will allow GTA HSPs to view all relevant healthcare information related to their patients at the point of care by connecting all the disparate clinical information systems of participating healthcare organizations within the GTA. The integration of these systems will help health care providers deliver better, faster and more coordinated patient care. With the support of information technology, ConnectingGTA will:

- Identify and collect priority data by developing a Clinical Data Repository to store electronic patient data
- Provide the ability to exchange information by establishing a GTA Health Integration Access Layer that will integrate and securely share clinical data from multiple sources
- Provide access to information that complements existing clinical practice including creating a provider portal and direct integration

ConnectingGTA is a multi-year and multi-stakeholder project that will be implemented in phases. By March 2013, the initial implementation phase will see more than 20,000 clinicians using the ConnectingGTA solution to access patient health information from across the GTA. The Toronto Central LHIN is a key partner in this project along with the other GTA LHINs (Central, Central East, Central West, and Mississauga-Halton), eHealth Ontario, Canada Health Infoway, and the University Health Network.

Diagnostic Imaging Repository (DI-r)

A Diagnostic Imaging Repository (DI-r) supports HSPs to share patients' diagnostic imaging results locally, regionally, and provincially and inter-provincially. The creation of a diagnostic imaging repository is a critical component of the interoperable electronic health record. The GTA West Diagnostic Imaging Repository (GTA West DI-r) will provide clinicians access to all patient images and reports acquired at any partner health care facility in the GTA West including 21 organizations, accounting for approximately 40 sites, across Mississauga Halton, Central West, Toronto Central, Central and North Simcoe Muskoka LHINs. As the largest of the four Diagnostic Imaging Repositories in Ontario, it will serve a population of approximately five million, accounting for approximately three million exams annually. The repository will establish a central archive for DI in the region, incorporating the latest archive technology and disaster recovery.

Diabetes Registry (DR)

The Diabetes Registry (DR) is an interactive, real-time information system designed to support better management of diabetes patient care according to recommended guidelines. Using existing provincial databases, the DR will support evidence-based decision making by capturing and trending lab results and dates for kidney function, cholesterol and blood sugar levels. It will also capture the date of the last retinal eye exam and primary care visit. Primary care providers can also enter additional information (e.g. blood pressure). The DR will be available to the patient's care team, ensuring a common understanding of the clinical information that informs the treatment plan. In the future, the DR will also provide patients with self-management guidance and tools. eHealth Ontario and the ministry are currently working to tailor the DR solution to Ontario's specific needs and have had a preliminary release of the DR to approximately 20 health care organizations in the Champlain and Southwest LHINs. The Toronto Central LHIN will be part of a wider provincial rollout in the future.

Integrated Assessment Record (IAR)

The Community Care Information Management (CCIM) Integrated Assessment Record (IAR) Viewer will enable care providers within the circle of care to access standard common assessment data in order to facilitate collaborative client care planning and delivery.

Key 2012/2013 Activity

- Continue the expansion of the TC LHIN RM&R Program: Expansion of the existing CCAC In-home, referral pathway into additional inpatient units, outpatient units, emergency departments and CSS agencies; expansion of the existing rehab/CCC and LTC referral pathways into additional inpatient units; implementation of RM&R for Women's College Hospital and the Centre for Mental Health and Addictions; implementation for behavioral supports beds; and further establishment of coordinated access model for community MHAs in preparation for RM&R implementations
- Continue participation in the provincial ALC RM&R BTI project with Cluster 2 LHINs
- Continue to work with the MOHLTC to define future phases of the provincial ALC RM&R project

- Complete initial implementation of ConnectingGTA, which will enable ~20 health service providers and ~20,000 clinicians access to shared data including: CCAC reports, diagnostic imaging reports, discharge summaries, emergency department reports, visits/encounter information, and ~74% of the GTA lab volumes from the Ontario Lab Information system (OLIS)
- Complete the GTA West DI-r solution implementations, contributing to Ontario having an integrated and interoperable provincial network to share digital images across the province.
- Continue local planning for the implementation of the diabetes registry at the direction of eHealth Ontario
- Continue phased implementation of the CCIM Integrated Assessment Record Viewer Toronto Central LHIN HSPs

2. LHIN Operations and Staffing Templates

Template B: Toronto Central LHIN Operations Spending Plan				
LHIN Operations ($)	**2011/12 Actuals**	**2012/13 Plan**	**2013/14 Outlook**	**2014/15 Outlook**
Operating Funding (excluding initiatives)	**5,783,555**	**5,555,121**	**5,826,421**	**6,022,595**
Initiatives Funding (e.g. E-Health, A@H, ED, Wait Time, etc.)	**1,933,588**	**1,932,913**	**1,794,785**	**1,751,035**
Salaries and Wages	4,114,053	4,328,260	4,852,702	4,949,756
Employee Benefits				
HOOPP	347,392	389,543	443,260	452,125
Other Benefits	556,593	562,674	661,529	674,759
Total Employee Benefits	***903,985***	***952,217***	***1,104,788***	***1,126,884***
Transportation and Communication				
Staff Travel	17,438	30,150	34,170	34,853
Governance Travel	481	-	6,120	6,242
Communications	43,612	52,200	108,018	110,178
Others				
Total Transportation and Communication	***61,531***	***82,350***	***148,308***	***151,274***
Services				
Accommodation	464,496	362,666	387,234	394,978
Consulting Fees	252,512	265,000	248,625	253,598
Equipment Rentals	18,453	16,285	16,611	16,943
Insurance	10,419	10,000	20,400	20,808
LSSO Shared Costs	652,491	342,000	367,200	374,544
Collaborative Expenses	26,971	47,500	51,000	52,020
Other Meeting Expenses	26,079	-	37,544	38,295
Board Chair's Per Diem expenses	22,050	35,000	42,840	43,697
Other Board Members' Per Diem expenses	25,825	90,000	105,570	107,681
Other Governance Costs	-	10,000	13,770	14,045
Printing and Translation	42,729	122,700	80,580	82,192
Staff Development & others	64,049	78,000	75,654	77,168
Other Services	620,642	568,713		
Total Services	***2,226,716***	***1,947,864***	***1,447,028***	***1,475,969***
Supplies and Equipment				
IT Equipment	351,117	-	3,531	3,602
Office Supplies & Purchased Equipment	61,038	177,343	64,849	66,146
Other S & E	-	-	-	-
Total Supplies and Equipment	***412,155***	***177,343***	***68,380***	***69,747***
Capital Expenditures				
LHIN Operations: Total Planned Expense	**7,718,440**	**7,488,034**	**7,621,206**	**7,773,630**
Annual Funding Target			7,621,206	7,773,630
Operating Surplus (Shortfall)	***- 1,297***	***-***	***- 0***	***- 0***

Template C: LHIN Staffing Plan (Full-Time Equivalents)					
Position Title	**2010/11 Actual**	**2011/12 Forecast FTEs**	**2012/13 Plan FTEs**	**2013/14 Outlook FTEs**	**2014/15 Outlook FTEs**
CEO	1	1	1	1	1
Senior Director	2	5	5	5	5
Executive Assistant	2	2	2	2	2
Administrative Assistant	3	4	4	4	4
Receptionist	1	1	1	1	1
Community Eng and Communications Consultant	1	1	2	1	1
Planner	1	1	1	1	1
Funding & Allocation Consultant	1				
Sr Perf/Cont/Alloc Consultant	4	3	3	3	3
Business Manager	1	1	1	1	1
Director	3				
Financial Coordinator	1	1	1	1	1
Financial Analyst	4	4	4	4	4
Program Dev Consultant	1	2	2	2	2
Sr Planner	1	1	1	1	1
Sr. Integration Consultant	5	4	4	4	4
Perf Measurement Analyst	4	3	3	3	3
Sr. Perf Meas Analyst	1				
Sr. Community Engagement Consultant	1	1	1	1	1
Communications Coordinator	2	3	1	3	3
Sr. Health Design Consultant	1				
Design/ PCO Consultant		2	2	2	2
Health Design Consultant	1	1	1	1	1
E-Health analyst		1	1	1	1
E-Health Senior Consultant		1	1	1	1
Senior Lead ALC RM&R		1	1	1	1
Senior Design/PCO Consultant		1	1	1	1
French Language Services Coordinator	1	1	1	1	1
Total FTEs	**43**	**46**	**45**	**46**	**46**

Key assumptions are:

1. TC LHIN will have a balanced budget for 2012/13 with a 5% reduction in revenues from last year's budget with some efficiencies and close monitoring will be undertaken to track progress

2. Other assumptions include:

    - Delay in filling vacancies
    - Deferral of repairs and maintenance
    - Productivity gains to be realized from prior year investments in SharePoint
    - Deferral in procurement of minor equipment

3. Communications Plan

Part 1 – General Communication Plan

Objectives: What is the purpose of the ABP?

- Inform health service providers (HSPs), community and other stakeholders in the TC LHIN about the ABP.
- Promote understanding of, support for and involvement in the implementation of the ABP initiatives.

Context: Why do we do an ABP?

The ABP guides planning and decision-making for the local health care system and is a mechanism for creating alignment with provincial health care policy and among the 14 LHINs.

The ABP sets measurable goals and deliverables so that we can track, measure and manage progress in the local health care system and communicate our priorities and progress to stakeholders and communities.

Target Audience:

Primary:

- MOHLTC
- TC LHIN-funded HSPs
- TC LHIN stakeholder and community groups – including advisory committees and working groups; Health Professional Advisory Committee, HSP CEOs/EDs/other administrative leaders; HSP Boards; consumer reference groups, French Language Health Services Planning Entity and interim Aboriginal Advisory Circle.

Other:

- General public in TC LHIN
- Patients and families who receive care in the TC LHIN
- Other health and community stakeholder groups

Strategic Approach: What type of announcement?

Once the Ministry approves the ABP and its release to the public, the TC LHIN will post the document on its web site. Early drafts will be shared with and discussed by the Board at public Board meetings.

Tactics:

Pre-release:

- Use TC LHIN engagement processes to seek ongoing input to shape the strategies in the ABP.

Release:

- Post on TC LHIN's public web site.
- Piece on ABP in TC LHIN news bulletin.

Part 2 – Communication Plan for Specific Initiatives

Specific Initiatives:

Reducing ER wait times and ALC

- Targeted stories about initiatives to reduce ER wait times and ALC emphasizing progress and benefits for patients, health care system; underscore message of supporting patients/clients to receive care in the right place at the right time and better quality of care and equity.
- Stories customized for different target audiences – HSPs; other stakeholders; Ministry; MPPs; general public, patients, community members; media.
- Repurpose messages and products for different audiences – print, web, social media, speaking opportunities/presentations
- Identify and prepare spokespeople – LHIN and third-party.

Resource Matching and Referral

- Update messaging and core communications products to support implementation in TC LHIN.
- Create patient benefit and results stories including case studies, testimonials, video and communicate using various mediums – news media, web, social media, speaking opportunities, publications
- Create an integrated provincial communications plan for the ALC Resource Matching and referral Business transformation Initiative including identification of communications milestones, core communications products – key messages, Q&A, fact sheets, template presentations, branded project bulletin.
- Identify and prepare spokespeople – LHIN and third-party.

Senior Friendly Hospital

- Profile success stories of Senior Friendly Hospitals
- Engage HPAC to provide health professional perspective on action plans in spring 2012
- Announce provincial action plan to media and stakeholders in March 2012
- Identify and prepare spokespeople – LHIN and third-party.

Mental Health and Addictions

- Update and enhance web, social media communications with stakeholders and public regarding TC LHIN MHA strategy and its progress and successes.
- Develop communications tools for stakeholders including storyboard regarding TC LHIN's MHA strategy, patient/client stories in various formats.

- Communications products and targeted media pitches regarding innovative projects and success in increasing access to mental health and addictions services – i.e. coordinated case management, supportive housing, links to primary care, and improving care across GTA LHINs.
- Identify and prepare spokespeople – LHIN and third-party.

Behavioural Supports Ontario

- Participate in coordinated provincial communications strategy including program launch, milestones and progress of program in local health care system.
- Identify and prepare spokespeople – LHIN and third-party.

Telehomecare/telemedicine pilot

- Participate in coordinated provincial communications strategy including announcing telehomecare and telemedicine pilots in TC LHIN to stakeholders using various vehicles and engagement processes and to media in Q4 2-11/12.
- Provide regular updates to all relevant audiences on progress emphasizing patient benefit stories.
- Identify and prepare spokespeople – LHIN and third-party.

5. LSSO 2012/13 ABP Submission

Introduction and Current Mandate

The LHIN Shared Service Office (LSSO) was established by Ontario's Local Health Integration Networks (LHINs) to achieve cost effectiveness, efficiency, and service consistency across the 14 LHINs.

LSSO is funded equally by all 14 LHINs. Its role is to provide back office services such as information technology, procurement, finance, accounting, payroll, human resources, and legal to all 14 LHINs.

The LHIN Legal Services Branch (LLSB) provides legal services to all LHINs through funding included as part of the overall LSSO budget, but the delivery of LLSB services is managed separately from the LSSO.

After the governance review in February 2011, LSSO's governance model was revised, and the LSSO became a division of the TC LHIN. The LSSO's Senior Director reports directly to the TC LHIN CEO, who is accountable to the TC LHIN Board.

In 2011, KPMG was engaged to commission a study to assess the 14 LHINs' collective needs and how to provide shared services in the most cost effective manner. To conduct this assessment, a Task Force which included representation from 13 of the 14 LHINs was convened. Through two task force meetings and working closely with Task Force members and LHIN staff, KPMG formulated a set of recommendations around which services LSSO is accountable to deliver as "core", meaning mandatory service delivery to all LHINs, which services are to be provided on an optional basis, and which services are to continue to be performed by the individual LHIN.

These recommendations spanned nine service areas: Information Technology, Procurement, Human Resources, Decision Support, Finance, Communications, Policy Development, Planning and Project Management. Of these nine, the first five were identified as priority services and the last four were identified as secondary services.

Recommendations for the Information Technology, Procurement, Human Resources and Finance service areas were approved by the 14 CEOs to proceed in fiscal 2011-2012, and the remaining recommendations to be approved at a later date. This business plan has been prepared taking into the account the Task Force recommendations.

Current Status

Departmental Operations- LSSO Operations

For the past year, the LSSO has worked with the LHINs to review the current and future strategy for the LSSO within the context of back office service delivery and support.

Based on these discussions with the LHINs and recommendations from the Task Force, both key functions and initiatives have been identified and included in this report. Both budget requirements and the estimated budget pressures have also been identified in this report.

LSSO is accountable for the delivery of both core and optional collaborative services. Core services are services in which all LHINs must participate, whereas the optional collaborative services represent additional service functions that will be shared across the LHINs. LHIN participation is encouraged to participate but not obligatory.

Item	Action Plan and Outcomes	Performance Indicator
LSSO Operations	• Ensure a smooth transition to the new shared service delivery model via an overarching committee, the Shared Services Implementation Committee (SSIC) • SSIC to develop a high level master plan for project, communications, transition, and resources needed to implement the approved recommendations of the Task Force • Continue to monitor overall project progress, manage and address conflicts • Review staffing needs and ensure LSSO has the right people to implement the service delivery model recommended by the Task Force • Finalize any additional budget for internal resources, staffing, and support for core and optional service delivery • Develop a change management plan • Develop a strategy to take accountability for the delivery of additional priority and secondary services identified by the Task Force • Establish policy development and project management committees to prioritize common initiatives and provide general guidance and direction with regards to common policies and project management approaches • Develop a communication plan to update LHINs of priorities and future directions • Review current staff skills and ensure staffs have the right skills to meet LSSO objectives. • Strive to improve IT project delivery and services through project planning and coordination.	• Implement recommendations from the Task Force within agreed time frame • LHIN satisfaction with LSSO services • Communicate project changes/updates to LHINs within agreed time frame • Projects are completed on time and within budget • Development of key performance indicators in support of user business requirements

Departmental Operations- Procurement Office

Procurement services are core. The LSSO is accountable for service delivery, but it is to outsource procurement services.

Procurement services include:

- Strategic sourcing – assess organizational spending and supply market, perform total cost analysis, identify suitable suppliers, and negotiate with chosen vendors.
- Creation of solicitation documents – develops and manages RFP/RFS/RFI/RFQ creation process/templates, compile requirements, draft documentation, and ensure tender documents comply with government directives.
- Management and tendering of solicitation documents – manage RFP/RFS/RFI documents including request documents, responses, vendor inquiries, written and evaluation responses.
- Development of contracts and contract negotiations – manage process to enter into contracts and purchase resources/business inputs from suppliers and vendors.
- Purchasing – work with LHINs and vendors on LHIN's behalf to procure goods and services that do not require formal tendering process.
- Exception based procurement – provide procurement expertise in exceptional situations
- Manage escalations
- Oversight of procurement guidelines
- Maintain repository of all tendering documentation and procurement related reports for all LHINs

Item	Action Plan and Outcomes	Performance Indicator
Procurement Office	• Establish the procurement office by April 2012 and stabilize it by the end of quarter 1 • Provide procurement advisory services, policy guidelines, and assist in RFP/RFS development when a vendor of record does not exist • Develop and manage RFP/FRS/RFI process and templates by September 2012 • Assess and determine our outsourcing requirements to find suitable vendor to deliver services • Manage, monitor, and ensure new vendor delivers services on a timely and accurate basis to LHINs • Monitor to ensure vendor complies with Government procurement rules and directives • Resolve conflicts between vendor and LHINs • Maintain open communication channels between LHINs and vendor • Minimize procurement activity at LHIN level • Monitor to ensure vendor response rate to LHIN request is acknowledged	• Percentage of procurement documents completed and delivered by specified date. • Percentage of procurement requests acknowledged upon receipt of request • RFP/RFS/RFI issued within specified time line • 100% compliance to OPS procurement rules and policies • LHINs satisfaction - Percentage rating according to pre-defined satisfaction index. Standard is about 80%.

Departmental Operations- Human Resources

HR services are core. The LSSO is accountable for service delivery, but it is to outsource HR services.

As there are unique regional needs and the need to understand local labor markets in recruiting, the Task Force identified the recruiting function as an optional service. The LSSO is accountable for service delivery, but it is to outsource recruiting on a cluster basis.

A review was done in early 2012 to assess and determine the business processes for human resources and finance solutions.

Core HR services include:

- Compensation management support
- Employee wellness (e.g. EAP, Occupational Health and Safety)
- Training and development
- Performance management guidelines
- On-boarding materials
- Labour/employee relations
- Expert advisory services
- Payroll
- Benefit administration
- Pension administration

Item	Action Plan and Outcomes	Performance Indicator
Human Resources	• Implement and stabilize payroll solutions by April 2012 • Develop a change management plan to ensure smooth transition to new solutions for payroll and HRIS • Implement an HRIS system by the 1st quarter and stabilize by the 2nd quarter • Assess staff core competencies to ensure right people are in place to manage, monitor, and ensure vendors deliver services to meet LHINs' operational needs. • Manage, monitor, and ensure selected vendor deliver payroll and HR services to LHINs on a timely and accurately basis • Assess staff core competencies to ensure right people are in place to implement business processes for human resources by the end of the fiscal year • Provide guidance and subject matter expertise on HR policy development • Implement standard and consistent HR practices and processes	• Successfully implement HRIS and payroll solutions in all LHINs within specified timeframe and budget • LHIN satisfaction with HR services (standard target is 85%) • Implement HR business processes on time • Payroll accuracy – number of files with no errors that require resubmission. Standard target is 99% • Payroll timeliness - Number of reports delivered within two business days or as agreed upon. Standard target is 99% • Benefit/pension administration responsiveness – number of customer issues resolved within agreed resolution timeframes (general one business day 85%

Environmental Scan of Opportunities and Risks

Technology Infrastructure Initiatives

IT services are core. IT services are currently being outsourced to a 3rd party vendor with LSSO accountable for the management and oversight of the contract. The Task Force identified the application development and maintenance support function as an optional service. The LSSO is accountable for service delivery, but it is to outsource this function.

Core IT services include:

- PC support and desk-side support
- Service desk
- Midrange (sever, email, database)
- Network
- Telecommunications
- Business continuity plan
- Security and access management
- Inventory/asset management

In consultation with the LHINs, LSSO has identified the following action plan as detailed in the table below:

Item	Action Plan and Outcomes	Performance Indicator
IT	• Improve the quality of service delivery through continuous project planning and coordination • Identify and use key performance indicators to measure outcome • Prepare and issue IT RFP for IT provider • Ensure new IT vendor to provide on-site support for local and remote offices as part of the contract services • Eliminate LHIN s' need to retain IT staff locally • Hire a vendor to provide custom application development and maintenance support, and LSSO to manage the contract • Develop a service category to provide clear definition of available services. Ensure this service category is communicated to all LHINs and is easily available to the LHINs • Clarify roles and responsibilities of LSSO and communicate this info to LHINs via intranet • Maintain open communication channels between LHINs and LSSO • Assess staff core competencies to ensure right people are in place to effectively manage IT vendor in delivery services to LHINs as well as to resolve issues between vendor and LHINs • Develop a change strategy and execution of exit from the current vendor contracts for IT infrastructure, financial system and payroll system services, which represent over 44% of the LSSO budget	• User satisfaction - the standard target for end user satisfaction is approximately 75%. • Timeliness of Moves, Add, Changes (MAC) -95% of MACs completed within 3 business days and 100% within 5 business days • Helpdesk calls: time to respond and time to resolve – 70% of calls answered and resolved on first contact during staffed hours • Service availability (application, network, telecommunications, email) – 99.9% of time service is available according to agreed upon timeframes • System/application performance – 98% of transactions within a specified timeframe • Projects implemented within agreed time frame and budget

Finance and Corporate Services Programs and Initiatives

Finance and accounting services are core. The LSSO is accountable for service delivery, but it is to outsource these services.

A review was done in early 2012 to assess and determine the business processes for human resources and finance solutions.

Core finance and accounting services include:

- Accounts payable
- Treasury management
- Accounts receivable
- Travel and expense management
- General accounting
- Financial planning
- Chart of accounts maintenance
- Financial reporting
- Fixed asset management
- External audit support

In consultation with the LHINs, LSSO has identified the following action plan as detailed in the table below:

Item	Action Plan and Outcomes	Performance Indicator
Finance	• Implement the finance and accounting system to meet LHINs requirement • Develop a change management plan to ensure smooth transition to new finance solution • Work with vendor to ensure all historical data is migrated to the new system and training is provided to staff • Assess staff core competencies to ensure right people are in place to implement business processes for finance by the end of the fiscal • Assess the new system options, business impacts, and transition processes prior to outsource finance functions to a 3rd party • Ensure a plan in place for back up capacity in the event that local finance resources are unavailable	• Successfully implement the finance and accounting system in all LHINs within specified timeframe • Implement the finance system that is integrated with HRIS and that meets LHINs' requirements on the long term • Sign off from LHINs to indicate that the finance system is implemented successfully • Develop a training plan that meets LHINs' needs

Project Management Initiatives

The Task Force identified project management function as a core service and the oversight and coordination of project related activities as an optional service.

Core project management services include:

- Consolidation of common tools, templates and methodologies
- Management of project resources, deliverables and common budget
- Project status and issue management for shared projects

In consultation with the LHINs, LSSO has identified the following action plan as detailed in the table below:

Item	Action Plan and Outcomes	Performance Indicator
Project Management	• Establish a project management committee to focus on leveraging common sets of tools, standards, and investments • Act as the committee secretariat to facilitate shared arrangements, track results and outcomes produced by the committee, promote investments in common shared opportunities • Develop standardized project tools, templates, methodologies and general project management guidelines • Provide advisory services on project management on shared projects amongst LHINs • Provide project expertise on local projects where local LHIN staff is engaged to carry out the actual project responsibilities	• Establish project management committee within specified time frame • Develop standardized project tools, templates, methodologies and general project management guidelines within specified time frame • User satisfaction - the standard target for end user satisfaction is approximately 75%.

Planning and Decision Support Initiatives

The Task Force identified the following decision support functions as core services.

- Common key performance indicators
- Leading working group for common services
- Market research, environmental scans and literature review
- Trending and forecasting
- Analytics for common business case development
- Shared analytical tool set
- Facilitate best practices and knowledge sharing such as data quality

The following functions are optional services.

- Data analysis for external stakeholders
- Support organization requirements for analysts/business intelligence (BI)

In consultation with the LHINs, LSSO has identified the following action plan as detailed in the table below:

Item	Action Plan and Outcomes	Performance Indicator
Planning and Decision Support	• Establish the project committee by the end of quarter 1 • The project committee is to identify the relevant stakeholders and complete an inventory and assessment of the available services and tools • Assess and determine the most appropriate method of collaboration on the decision support function • Recommend decision support collaboration options and shared analytical tool set • Liaise with internal staff and external subject matter experts to develop key performance indicators for various LHIN stakeholders and priority groups • Work with project leads to develop analytical reports to monitor performance and assist in decision making • Provide analysis for business case development to assist in decision making	• Report creation and delivery within specified time frame • Committee established within specified time frame • Develop decision support function tool set within agreed time frame

Relationship Organizational Management Initiatives

As LHINs have evolved, their support requirements to effectively carry out their mandate have also changed.

Therefore, the LSSO's strategies and operations will need to change to best provide shared services to 14 LHINs in a cost effective manner.

To implement the service delivery model recommended by the Task Force, the LSSO will need to become a relationship management organization such as managing and overseeing service level agreements with third party vendors to ensure services are delivered to LHINs.

In consultation with the LHINs, LSSO has identified the following action plan as detailed in the table below:

Item	Action Plan and Outcomes	Performance Indicator
Relationship Organizational Management	• Prepare business cases to access service delivery provider options for each initiative to ensure risks and benefits are considered before outsourcing services to external providers. • Review staffing requirements to ensure LSSO has the right people to provide, coordinate, monitor and manage service delivery to LHINs • Hire or train current staffs that have the core competency skills to implement the service delivery model recommended by the Task Force.	• Achieve activities (i.e. business cases, staffing requirements, etc) as per specified time frame and within budget • LHIN satisfaction

SharePoint Initiative

The SharePoint initiative is a web-based intranet platform that is developed by the LSSO using the SharePoint 2007 platform to improve operational efficiencies through information collaboration and document management.

This project has two phases. Phase I, implementing the SharePoint portal at 14 LHINs, was completed at the end of March 2012.

Phase II will begin in fiscal 2012-13. The deliverables for Phase II will include:

- Develop and implement integrated business solutions that will include Performance Point, CRM, and SharePoint
- Develop document management strategies
- Develop a SharePoint governance strategy for LHINs to adhere to
- Develop collaboration management strategies
- Integrate existing HSP SharePoint sites so LHINs can collaborate with HSPs
- Data migration
- Training and support

In consultation with the LHINs, LSSO has identified the following action plan as detailed in the table below:

Item	Action Plan and Outcomes	Performance Indicator
SharePoint	• Prepare a business case that will include CRM, Performance Point, and SharePoint integration to support phase II implementation • Develop RFS/RFP to implement phase II • Continue to work LHINs to better understand LHINs' operational and functional needs • Develop and implement a training plan that will meet LHINs' needs • Develop and implement a document migration strategy that is in line with best practices • Prepare a communication strategy to update changes to LHINs, staff, and key stakeholders • Develop and design workflow strategy to streamline work processes	• Project is completed on schedule and within budget • Training tailored to LHINs' needs • Employee satisfaction with the application via survey • Improve access to data and documents via survey • 99% system sustainability with limited downtime

Risk Assessment

The following risks have been identified and might impede LSSO's pursuit of stated objectives:

Description of Risk	Impact of Risk	Response
Balanced budget with increase in service requirements and initiatives (e.g. procurement office, project management, decision support & planning)	• Turn-around time lengthened (including the time which LSSO promised to deliver services) • Increased risk of deals that may not be cost-effective • LSSO jettisoning some areas of current responsibility	• Reduction in spectrum of work LSSO has taken on/can take on • Will not initiate project until funding is secured
Failure of LHINs to grant additional staffing request due to increase in support requirements/projects	• Turn-around time lengthened (including the time which LSSO promised to deliver services) • Current staff may not have the right skills to implement the service delivery model recommended by the Task Force • Increased risk of deals that may not be cost-effective • LSSO jettisoning some areas of current responsibility	• Reduction in spectrum of work LSSO has taken on/can take on • Will not initiate project until funding is secured
Various project implementations will depend on internal subject matter experts (e.g. SharePoint, CRM, Finance & HRIS, etc)	• Project may be delayed if internal subject matter experts are not available due to other project commitments, on vacation , leave of absence • Revise timeline and communicate to stakeholders, LHINs, committees	• Third party experts are available if and when required
Adequate and available LHIN staffing resources	• Employees are heavily involved in daily operational efforts • Daily operations may be affected if employees are deployed to work on initiatives (e.g. implement systems or solutions) • Project completion may be delayed if inadequate staffing resources	• Hire additional staff either to assist in daily operational needs or hire additional staff to help with system implementation

Financial Summary

Template B: LSSO Operations Spending Plan			
LHIN Operations Sub-Category ($)	**2011/12 Actual**	**2012/13 Budget**	**2013/14 Planned Expenses**
Salaries and Wages	***1,727,135***	***1,657,544***	***1,740,285***
Employee Benefits			
HOOPP	58,828	85,681	91,460
Other Benefits	152,128	221,568	236,513
Total Employee Benefits	***210,956***	***307,249***	***327,973***
Transportation and Communication			
Staff Travel	12,699	25,154	22,552
Governance Travel	-	-	-
Communications	17,717	32,000	21,910
Total Transportation and Communication	***30,416***	***57,154***	***44,462***
Services			
Accomodation	160,499	172,040	178,455
Consulting Fees	173,494	30,000	101,372
LSSO IT Contracted Services	2,066,587	2,115,538	1,926,772
Other Services	71,265	49,539	38,950
Total Services	***2,471,845***	***2,367,117***	***2,245,549***
Supplies and Equipment			
IT Equipment and Software	944,843	274,214	128,535
Office Supplies & Purchased Equipment	23,690	18,000	94,474
Total Supplies and Equipment	***968,533***	***292,214***	***223,009***
Projects in support of LHINs	***-***	***100,000***	***200,000***
One-time initiative expenses	***-***	***700,000***	***900,000***
LSSO Operations: Total Expense	5,408,885	5,481,278	5,681,278
Annual Funding Target - To be funded by the LHINS		4,781,278	4,781,278
Variance		700,000	900,000
% Increase to be funded by LHINS		14.6%	18.8%
ADDITIONAL FUNDING REQUIREMENTS			
Renew, Rebuild, Refresh Project Funding requirements, currently under review by MOHLTC for short term one-time funding of the project. Pending approval. Assumes it will be repaid to the MOHLTC in annual increments from 2012-13 through 2013-14		**$ 700,000**	**$ 900,000**

Staffing Plan

Position Title	2011/12 Actual FTEs	2012/13 Forecast FTEs	2013/14 Forecast FTEs
Senior Director	1	1	1
Administrative Assistant LSSO/LHINC	1	1	1
Controller	1	1	1
Senior HR Manager	1	1	1
LHIN Leadership Council Executive Coordinator	1	1	1
Procurement Specialist	1	1	1
Procurement Administrator Assistant	-	-	1
IT/PMO Manager	1	1	1
LSSO IT Support	1	1	1
LSSO IT Support Coordinator	1	1	1
Project Manager	-	-	1
Project Coordinator	-	-	1
SharePoint Administrator/Developer	1	1	1
Administrator Assistant - Legal	1	1	1
Payroll Specialist	1	1	1
Financial Analyst	1	1	1
Total FTEs	13	13	16

2012-13 Budget and 1 year (2013-14) forecast assumptions

The following assumptions were considered when compiling the budget and 1 year forecast:

- All vacant positions are budgeted at mid-range of the pay scale group for the corresponding positions.
- Employee Benefits are substantially increased to reflect projected changes in positions and status.
- Staff benefit costs are budgeted at 16% of salaries for all positions.
- The costs for the LHIN Legal Services Branch are included in the budget.
- The budget does account for 5% decrease following a reduction in the 14 LHINs' contribution.
- The rent cost is based on the cost of the lease agreement.
- The one-time costs of the initiatives are identified as a separate line item and are nil as most IT transition costs incurred earlier.

Budget commentary

The significant points of note about the budget and forecast are:

- The LSSO budget for 2012-13 was based on a 5% reduction in revenues following the 5% decrease in contribution from the 14 LHINs and no adjustment to reflect one-time additional funding for IT, Finance, and payroll implementation and transition costs as they were mostly incurred in 2011/12.
- Any staffing required for future projects or initiatives not included in this document would be funded through project funding from the LHINs as those projects are requested and approved.

Funding Pressures

- The IT services and Finance service contract expired in March 2012, and the LSSO extended the current contracts for a period of time to enable the transition of new service providers.
- LSSO had partially implemented the new accounting system during 2011/12 and additional funding of $1.6 million over two years is projected to be needed to complete the project.
- This additional funding requirement of $1.6 million is over and above the funding provided by the 14 LHINs for the next two years.

Operating Budget Summary

- $2 million - salaries and benefit costs for 13 FTEs, including legal services
- $2.1 million - IT Contracted Services costs represent 3 vendor contracts for back office services, external website support, and backup and storage of external website content.
- $274K – supplies and equipment costs are for hardware and software maintenance renewal costs, annual software license costs where required, supplies, and other miscellaneous expenses.
- $172K - costs for rent costs and other accommodation costs.
- $100K - various project costs, services, and reporting tools in support of LHINs.
- $57K – transportation and communication costs are for staff travel & telecommunication

Capital Budget Summary

- $1.6 million is identified as one-time capital investment to complete IT infrastructure. Of the $1.6million, $0.7 million is estimated to be spent in 2012-13 fiscal year and $0.9 million is estimated to be spent in 2013-14 fiscal year.

LSSO Projects and Initiatives Identified for the 2012-13 ABP Planning Cycle

Projects and Initiatives	Fiscal 2012-13			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Finance and HRIS System				
Finance Business Processes				
Human Resources Business Processes				
Payroll Solutions				
Information Technology				
Planning & Decision Support (TBD)				
Business Intelligence (TBD)				
Procurement Office				
Project Management				
Relationship Organizational Management				
SharePoint				
CRM				

LHIN Collaborative - 2012/13 ABP Submission

Background

The LHIN Collaborative (LHINC) was established in 2009 as a provincial advisory structure to the LHINs, engaging health service providers, their associations and the LHINs collectively on system-wide health issues. In 2011, the LHIN CEOs and Board Chairs undertook a comprehensive review of LHINC's role with a goal to further enhance system level engagement and improve strategic support provincially to respond to emerging system priorities of health system sustainability, quality and patient centered care. As a result of this evaluation, the LHINs approved an expanded mandate for LHINC in the Fall of 2011, which includes a new governance and oversight structure, expanded responsibilities, and a stronger role in health system engagement.

Expanded Mandate

LHINC's new role will make it more aligned, more responsive and more effective:

- Enabling a stronger voice on key system issues
- Facilitating system engagement and dialogue on key strategic issues
- Improving utilization of limited resources and expertise across the system
- Ensuring a collective, timely LHIN response to emerging issues
- Delivering tools and resources for sharing knowledge and leading practices across LHINs

In addition to supporting pan-LHIN projects, LHINC will take a greater role in strategic communications, knowledge management and collaboration, and building system capacity for analysis, research and monitoring. LHINC will take on greater secretariat support roles for the System Strategy Council, Pan LHIN Committees as well as the LHIN Leadership Council composed of LHIN CEOs and board chairs.

2012/13 Business Plan

In accordance with its mandate, LHINC's ABP is based on priorities that are identified by the LHIN and health system leadership tables, primarily the LHIN Leadership Council (composed of LHIN CEOs and Board Chairs) and the System Strategy Council (Composed of LHINs and health system and sector leaders).

2012/13 will be a building year for LHINC as the organization puts in place the team, infrastructure and processes to support its expanded mandate.

Supporting System Strategy:

Research, analysis and strategic engagement on key system priorities for 2012/13:

- *Integration and patient centred care* – supporting LHINs and other health system leaders to work toward a common framework for integration as a key driver for sustainability, quality and patient centred care
- *Sustainability and value* – improving research and analysis on issues of sustainability to inform system decision-making and priority-setting

- *LHSIA review and health system transformation* – working across the system to identify opportunities to enhance the legislation and supporting ongoing dialogue throughout the review

Improving Communications and Secretariat Capacity within LHINC:

- Establish effective system communications channels – between LHINs, with MOHLTC and other health system leaders on system priorities
- Supporting timely, coordinated response among LHINs

Providing Effective Project Support for Pan-LHIN Initiatives:

- Streamlining and enhancing LHINC project support for SAA processes and indicator initiatives
- Introducing knowledge management and collaboration tools across LHINs and other system stakeholders

Establishing New Engagement Structures:

- Establishing a new System Strategy Council and other vehicles to engage health system leaders
- Establishing Pan-LHIN Operations and Strategy Council to ensure alignment between LHINC and the broader system priorities

Appendix – Selected 2011/12 Projects

Selection of 2011/12 Projects Completed to Date:

- Health System Indicator Initiative (Phase I and II)
- Mental Health & Addictions: Improving Access to and Coordinating Health Services
- Analysis of LTC Issues across LHINs
- Transition Management: Home First Toolkit
- Aging at Home Review
- Community Funding Allocation Review
- Hospital Quality Improvement Plans Implementation Survey and Review (QIPs)
- CAPS and M-SAA Process Review and Evaluation
- CCAC Enhanced Role Review
- Ongoing support for development of Service Accountability Agreements

Template C: LHINC Operations Spending Plan

LHIN Operations Sub-Category ($)	2011/12 Actual	2012/13 Budget	2013/14 Planned Expenses
Salaries and Wages	***637,932***	***854,194***	***870,831***
Employee Benefits			
HOOPP	31,979	40,695	39,955
Other Benefits	115,366	146,811	144,139
Total Employee Benefits	***147,345***	**187,506**	***184,094***
Transportation and Communication			
Staff Travel	1,391	1,000	1,000
Governance Travel	-	-	-
Communications	22,727	31,820	26,000
Total Transportation and Communication	***24,118***	***32,820***	***27,000***
Services			
Accomodation	94,604	99,900	99,900
Consulting Fees	28,668	37,780	30,375
LSSO IT Common Services	80,000	44,400	44,400
Other Services	6,092	4,500	4,500
Total Services	***209,364***	***186,580***	***179,175***
Supplies and Equipment			
IT Equipment and Software	10,058	16,000	16,000
Office Supplies & Purchased Equipment	18,771	24,400	24,400
Total Supplies and Equipment	***28,829***	***40,400***	***40,400***
LHINC Operations: Total Planned Expense	***1,047,588***	***1,301,500***	***1,301,500***

Position Title	2010/11	2011/12 Forecast FTEs	2012/13 Outlook FTEs	2013/14 Outlook FTEs
Senior Director	1	1	1	1
Administrative Assistant	1	0.5	0.5	0.5
Senior Consultant	1	1	1	1
Senior Consultant	1	1	1	1
Senior Consultant	0	0	0.5	0.5
Project Consultant	1	1	1	1
Project Consultant	1	1	1	1
Project Consultant	1	1	0.5	0.5
Project Consultant (Communications)	0	1	1	1
Project Assistant	1	1	1	1
Total FTEs	8	8	8	8