

Annual Business Plan: 2013/14

Toronto Central LHIN

Final

CONTEXT

- 1. Transmittal Letter**
- 2. Mandate**
- 3. Overview of Agency's Current and Forthcoming Programs and Services**
- 4. Assessment of Issues Facing Agency**

CORE CONTENT

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- 2. Performance Measures and Targets**
- 3. Proposed operation expenditures, projected revenues, funding requirements**
- 4. Resources needed to meet goals and objectives**
- 5. Initiatives involved third parties**
- 6. Risk assessment and management**

LHIN STAFFING AND OPERATIONS

- 1. Summary of staff numbers; impact of business plan on human resources; compensation strategy**
- 2. Proposed capital expenditures**

COMMUNICATIONS PLAN AND ENGAGEMENT PLAN

- 1. Details of communications engagement activities for the Annual Business Plan (ABP)**

LSSO AND LHINC SUBMISSIONS

June 18, 2013

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

Dear Ms. Brown,

I am pleased to present you with the Toronto Central LHIN's (TC LHIN) Annual Business Plan (ABP) for 2013/2014.

The ABP sets out a focused set of action steps designed to achieve the Ministry's and the TC LHIN's priorities in key areas: improving care for the high needs (1% and 5%), improving the patient experience, improving value and efficiency of health care resources and sustaining our gains.

This plan is designed to support and advance the Ministry's Health Care Action Plan and transformation initiatives including Health Links and the Seniors Care Strategy.

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

Sincerely,

A handwritten signature in black ink that reads "Angela Ferrante". The script is cursive and fluid, with the first name "Angela" and last name "Ferrante" clearly distinguishable.

Angela Ferrante
Board Chair

Annual Business Context

Mandate and Strategic Directions

The Toronto Central LHIN's (TC LHIN's) 2013-2016 Integrated Health Services Plan (IHSP-3) is guided by Ontario's vision: *To Make Ontario the Healthiest Place to Grow Up and Grow Old.*

The TC LHIN's focuses on where we can have the greatest impact on patients and the health system: the 1 % of the population that accounts for 34 % of health costs and the 5 % of the population that is at risk but are able to maintain independence with the right services and support. As a system we often fail these high-needs patients. They are often not receiving the right care in right place and have avoidable health problems. We can do more to improve their quality of life and outcomes.

TC LHIN's Aim:

Transform the system to achieve better health outcomes for people now and in the future

Strategic Priorities:

1. Address the needs of the 1 % of highly complex patients with the greatest needs, requiring the most resources.
2. Prevent and delay serious illness and injury among those who are at greatest risk of declining health
3. Improve the patient experience
4. Deliver value and sustainability through efficient use of resources
5. Sustaining our Gains

Overview of current and forthcoming programs / activities

The TC LHIN has the highest concentration of health services in Canada, with 170 unique health service providers (HSPs) in the TC LHIN which offer a total of 208 unique programs.

Activity by sector (to be updated for 2013-14)

- 17 hospitals with a total of 2.19 M patient days.
- 17 community health centers (CHCs) providing an estimated 368,700 primary care face-to-face encounters.

- 67 agencies providing community support services (CSS) totaling an estimated 848,037 visits and 981,129 resident days.
- 69 agencies that provide mental health and addictions (MHA) and problem gambling services totaling an estimated 1,132,115 visits.
- 1 community care access centre (CCAC) providing estimated 3,458,660 visits/hours of care and case coordination.
- 37 long-term care (LTC) homes accounting for almost 5,966 long-term care beds (equivalent to 2,177,590 days).

Many HSPs offer services that fall within multiple programs:

Program Types	# of TC LHIN HSPs
Only Hosp	4
Only LTCH	29
Only CHC	15
Only CCAC	1
Only CSS	54
Only CMHA	50
CSS & CMHA	6
CHC & CMHA	2
Hosp & CMHA	8
CSS & LTCH	3
Hosp & CSS & LTCH	2

The TC LHIN's base transfer payments budget is \$4.463 B.

HSP Budgets 2012/13

	<u>Base</u>	<u>One time</u>	<u>Total*</u>	<u>% of Total Funding</u>
Hospital	3,400,257,781	26,338,367	3,426,596,148	76.29%
Grants-MunTax-Public Hospitals	751,125		751,125	0.02%
Long Term Care Homes	252,724,779	250,000	252,974,779	5.63%
Community Care Access Centres	211,321,301	352,500	211,673,801	4.71%
Community Support Services	73,070,660	5,933	73,076,593	1.63%
Asstd Living Serv-Supportive Housing	44,602,537		44,602,537	0.99%
Community Health Centres	84,482,661	1,013,625	85,496,286	1.90%
Community Mental Health	102,464,654	380,000	102,844,654	2.29%
Addictions Program	27,511,207	95,000	27,606,207	0.61%
Specialty Psych Hospitals	246,715,745		246,715,745	5.49%
Grants-MunTax-Psych Hosp	44,550		44,550	0.00%
Acquired Brain Injury	1,813,670		1,813,670	0.04%
Initiatives	17,540,300		17,540,300	0.39%

Total	4,463,300,970	28,435,425	4,491,736,395	100%
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Environmental Scan

Uniquely Urban, Diverse Population

Toronto Central LHIN is the only LHIN in Ontario's 14 that is completely urban. Home to 1.15 million people, TC LHIN is an extremely diverse area in terms of the population who lives here and the hundreds of thousands who come to the city for health care. In fact, more than half the patients in TC LHIN-area hospitals are from out of town and 41 percent of alternate level of care patients discharged from hospitals in the city live in other LHINs.

In TC LHIN, 41 percent of residents are residents, 8.3 percent of whom arrived in Canada between 2001 and 2006. 170 languages and dialects are spoken in Toronto. While they contribute to the wonderful diversity of the city, newcomers face barriers to care, particularly if they are unable to speak English. Today 4.5 percent of the population reports no knowledge of either official language.

TC LHIN is also home to approximately 16,200 Aboriginal people, one of Canada's largest Aboriginal populations in Canada. Toronto's highly diverse Aboriginal community is made up of many different First Nations communities from across the country.

Toronto also has a substantial Francophone population of 53,000 (9.2 percent of Ontario's Francophone population) many of whom are recent immigrants/and or visible minorities. Francophones are increasingly diverse with 49.8 percent born outside of Canada and a high proportion of recent immigrants, largely from African countries.

Issues facing the TC LHIN

LTC home capacity

There are two main risks regarding long-term care homes (LTCHs) in Toronto. There is a high probability that the TC LHIN will lose a significant proportion of LTC H beds as homes leave the sector or locate outside of Toronto due to the high costs of building and operating in the city. 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. Access to long-term care is a significant issue. LTCHs are at 103.3% occupancy and the median time for a client to be placed in a LTCH is higher than the provincial average (112 days vs. 89). TC LHIN has the third lowest long-term care bed to population ratio in the province. At the same time, LTCH residents have increasingly more complex needs, requiring specialized services that many homes are currently not equipped to provide. Any further loss of LTCH beds would have a profound impact on TC LHIN's ER wait times and alternate level of care (ALC) performance and patient access to the appropriate level of care.

Long-Stay ALC

One of the main contributors to ALC is hard-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 103.3% LTCH 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. TC LHIN Academic Centres are committed to providing these highly specialized services to patients referred to them and patient choice is important. However, the challenge is in repatriating these patients after their treatment is completed. As a result, 41% of ALC patients discharged from TC LHIN hospitals live in other LHINs. Also some patients coming to the TC LHIN for secondary and quaternary specialized acute care are not returning home for follow-up care. This challenge repatriating patients back to their home LHIN contributes to budget pressures and ALC rates and impedes patient flow in the TC LHIN.

Quality Based Funding (QBPs) – unintended consequences

TC LHIN developed a plan for stroke, musculoskeletal and hip fracture patients. The plan is to move the right patients into inpatient beds (stroke, hip fractures) and move the appropriate patients to outpatient settings (Total Joint Replacement). While the QBPs will create incentives for hospitals that have not yet implemented best practices for total joint replacement, hip fractures and stroke, at this time it has resulted in unintended consequences for Toronto inpatient rehabilitation hospitals that have already made changes to meet best practice guidelines. The TC LHIN's (Health System Funding Reform (HSFR) Local Partnership and the Ministry are discussing ways to mitigate and address these impacts.

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 two years). This trend could have a very significant impact on health service providers' funding for clinical and other programs.

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. Provincial health care capital planning and funding processes were largely designed to support hospital capital planning and do not always fit the needs and models of care of community agencies, particularly those servicing specific populations such as Aboriginal people. The TC LHIN is working with the Capital Branch and Infrastructure Ontario to explore approaches that adapt to the realities and needs for community health services.

Readmission rates

TC LHIN has the highest hospital readmission rate within 30 days of any LHIN. This can be explained in part by the complexity of patients in TC LHIN hospitals. However, there is a concerted effort involving all sectors underway to uncover the factors leading to avoidable

hospitalizations. Stronger and better integrated primary care and community-based services will be central to the solution.

Community capacity

Local efforts to build the capacity of the community sector including leveraging the four % funding increase and for community services and the inclusion of community services over the next few years in Health Links will help provide the community sectors the needed tools, infrastructure to enhance their services and integrate with each other and the rest of the continuum of care. TC LHIN has 68 community support service organizations and 69 community mental health and addictions agencies and a great deal of fragmentation and variability in terms of the size, organizational capacity and types of services provided. There appears to be a mismatch between population need and location and type of services. TC LHIN is undertaking significant efforts to transfer ALC patients from hospitals to more appropriate destinations in the community. It will take time to create sufficient capacity across the community sectors for them to meet the needs of an increasingly complex client population and fully contribute to ALC reduction efforts.

Refugee Health

The federal government's changes to the Interim Federal Health Program (IFHP) pose significant health care risks to an already vulnerable population.

The most significant change to the IFHP is that refugees whose claims have been accepted and refugees who have claims pending will no longer have access to basic health care services or supplemental benefits; the program will only provide access to urgent or essential health services and no supplemental benefits (medication will only be provided if needed to prevent or treat a disease that is a risk to public health). Toronto receives approximately 40% of all refugees and immigrants to Canada.

A number of harmful impacts are already being seen. If the IFHP does not provide basic health services then there could be pressure on programs that specialize in refugee health services or on Emergency Hospital services. There will also be obvious equity issues for this population.

The Toronto Central and Hamilton Niagara Haldimand Brant LHINs are the leads for this issue on behalf of all LHINs. TCLHIN will continue to raise the issue with MOHLTC and present mitigation strategies that retain the necessary funds and resources for appropriate patient care.

Template A: Parts 1 and 2

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Address the needs of the 1% of highly complex patients with the greatest needs, requiring the most resources.
IHSP Priority Description:
The TC LHIN will focus on the 1% of the population that accounts for nearly one-third (29% in TC LHIN, 34% provincially) of health care costs in the TC LHIN to improve their quality of care, outcomes, experience and to reduce the cost of their care. The LHIN will collaborate with the Ministry of Health and Long Term Care, the Institute for Clinical Evaluative Sciences (ICES) and others to undertake a thorough analysis of the sub-populations within the 1% high-needs, high-use group (also called “super users”) to create a profile of the populations who are not receiving appropriate care and for whom we can make a difference to their outcomes and cost of care. We will target initiatives to improve care transitions and supports for these populations so that they can receive the appropriate care in the right place. Some in this varied group are receiving the right care in the right place. The TC LHIN’s strategy is to target those who are not receiving appropriate care. The system changes that will be made for these high-needs patients will have a positive ripple effect for everyone. For example, by having hospitals routinely communicate essential information about the patient when they are discharged back home or into the care of a family physician, all patients in the TC LHIN will benefit.
Current Status:
Profile, services and providers for the 1% population 1% of the people who use TC LHIN hospital and homecare services account for 29% of the health care costs. A total of 450,465 patients used TC LHIN services in 2009/10 at a total cost of \$2,774 M. This includes TC LHIN residents and non-residents. The 1% highest users among these (4,505) accounted for \$806 M (which is equal to 29% of the total cost or \$2,774 for TC LHIN). - The people within the “1%” group are seriously ill. There is a low likelihood of being able to prevent or slow their disease. Some are at the end stage of life. The sub-populations have special needs and require their health, social and community services to be tightly coordinated. - It is estimated that 44% of this group are over the age of 65 and 23.8% are middle-aged which includes a proportion who are living with degenerative diseases. Of the 8.7% of patients who are aged one to 17 years old, older teens face the challenge of moving from the children’s system to

the adult system. A proportion of the infants in the 1% group are receiving highly specialized care (many from the Hospital for Sick Children) and could not be safely cared for at home or another location.

Mental Health and Addictions

- The highest costs are associated with patients with serious mental illness and addictions. On average, per patient costs of mental health clients (\$176,000)
- Adults aged 18 to 44 use inpatient mental health and addictions services more than any other group (43.3% of use)

Other characteristics

- 52% of the 1% population comes from other areas of Ontario outside of the TC LHIN.
- The majority of care type events for the 1% fall within Acute Care and ED. Of note, Super High Users have many more care type events in Complex Continuing Care than do High Users (5% of patients).
- About 50% of seniors in the 1% group receive home care.

Key issues

- The health system often fails these patients. Many within this group do not receive the right care in the right place. Their care is often poorly coordinated, fragmented and too often inappropriate. They represent a high proportion of avoidable Emergency Room (ER) visits and Alternate Level of Care (ALC) patients. Their challenges usually occur during transitions from one part of the care continuum to another.
Patients who have been ALC for a long time (over 40 days) make up a large portion of total ALC in the TC LHIN.
- Evidence suggests disproportionately high use among high needs/ vulnerable populations, for example, seniors, people with mental health and addictions, people with multiple chronic conditions, people living in certain geographic areas, along with ethno-racial groups such as Aboriginal.

Successes of the past year

Over the past year, TC LHIN completed significant analyses to understand the highest users of the healthcare system. The LHIN analyzed data provided by the Ministry to understand the distribution of high users among different age groups, gender, disease groupings, and care settings. Data analyses were supplemented by literature reviews, consultations with experts (e.g. Quality Table), and geographic mapping of high users requested by the LHIN of Toronto Community Health Profiles Project (TCHPP). This analysis has provided a good picture of the high users in TC LHIN and TC LHIN recently presented its approach to High User analysis at a Ministry-organized conference.

Improving patient discharges

By the end of 2012/13, all GTA hospital CEOs that are part of GTA Health Information Collaborative (HIC) will have approved the standardized data elements for discharge summaries. In 2013/14, the focus will be on implementing standard data elements in all TC LHIN hospitals.

The project will:

- Support and improve communication and coordination between and within the community/primary care providers, hospital, post-discharge care providers, and patients and families
- Provide a more consistent mechanism to support care transition
- Improve the continuity and coordination of care, and reduce medical errors
- Increase patient satisfaction and reduce hospital readmissions and patient complications

TC LHIN also provided leadership for the first phase of an associated project called Hospital Report Manager (HRM) to enable hospitals to electronically transmit patient reports to directly to physicians' EMRs. This will allow timely development and communication of treatment plans or referrals to specialists and improve physician/patient interactions because physicians will be able to spend more time with patients. The technical effort required to support HRM is being harmonized with the Connecting GTA project to maximize efficiencies and reduce duplication. By the end of 2012/13, three early adopter hospitals will implement HRM in the TC LHI and an additional 10 hospitals will implement HRM in 2013-14.

Palliative Care

A multi-sectoral Palliative Steering Committee was created to support development of a system-wide approach to improving palliative care across the continuum. The initial work has focused on confirming the strategic objectives and actionable initiatives, including the establishment of a central bed registry for palliative beds in the TC LHIN. A Working Group is supporting implementation of the central palliative bed registry.

Measuring and Improving Quality

- Last year the LHIN launched a different approach to measuring and addressing health quality. TC LHIN brought all parts of the health system to the table from hospitals to community health centres to primary care to public health. Patients and caregivers provided feedback throughout the process.

All sectors and providers are now accountable for tackling their part of problems including avoidable ER visits, hospital readmissions and improving the patient experience. These quality indicators are now being included in the LHIN's accountability agreements with health service providers, linking funding to quality improvements.

- Integrated Care for Complex Populations (ICCP) brings together different parts of the health system to better meet the needs of clients who require the highest levels of care. The strategy addresses the gaps where the system fails people and their families most. ICCP expanded from 200 seniors to 1,500 frail/complex seniors. Through this strategy, each ICCP client:
 - Has intensive case management support from a CCAC Care Coordinator, who acts as a 'quarterback' for the clients and their caregivers.
 - Has primary care Physicians and CCAC Care Coordinators working hand-in-hand to support their care as well as other members of an inter disciplinary care team.
 - Has their own Emergency Department Transfer package at home that includes essential

medical history information and medication lists to enable a safer and far easier experience when they have to call EMS to go to the hospital. ICCP Clients are also included in a flagging system that alerts their care team if they are taken to an ED so that the care team can determine what is required for the client's discharge home

- Has a single pharmacist/pharmacy in the community to help them manage their medications
- Has access to dedicated training for caregivers/family.

TEMPLATE A: PART 2: GOALS and ACTION PLANS

Goal (s)

Our goal is to ensure patients in this group are transferred to and managed in the most appropriate place and outside of hospital whenever possible, and that they receive care according to best practices, while respecting their preferences.

- Evidence has shown that initiatives aimed at providing intensive and focused case management support helps this group navigate the system and allows caregivers to have their needs met.
- The resources freed up through better management of these patients will be reinvested in other needed services.

The TC LHIN will:

- Work with providers and researchers including Toronto Community Health Profile Partnership (TCHPP) and ICES/CRICH to **understand the profile of the 1%, impact on costs, their outcomes and their barriers and needs.**
- Work with patients, providers and other stakeholders to develop a standard discharge summary for use by TC LHIN hospitals. Discharge summaries will be sent electronically to “early adopter” primary care providers’ electronic medical records (EMRs), starting with specific geographic areas and high-need populations.
- Undertake a strategy to redesign and integrate palliative care services to support the best possible end-of-life experience for people. This system will provide strong community-based palliative care services; effective transitions to the more appropriate place of care; a continuum of services that meets people’s diverse needs; and equitable access to services.
- Help patients of all ages with behavioural issues – many of whom are long-stay ALC - to receive equitable access to appropriate care in the right place, resulting in an enhanced patient experience and less avoidable institutionalization.

Consistency with Government Priorities:

This aligns most with the Health Action Plan priority Right Care, Right Time, Right Place.

“Right Care” means care informed by what the best scientific evidence and clinical guidelines have determined is the best care for patients.

“Care at the Right Time” means having faster access to the care a person needs.

“Care in the Right Place” addresses several serious issues in the health care system. One of the most pressing is the challenge of Alternate Level of Care (or ALC) patients, who are in hospital beds, but would be best cared for in the community.

Action Plans/Interventions

Action Plans	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Create a detailed profile of the 1% high-needs population , to understand the sub-populations and their specific needs, barriers and costs, and develop improvement strategies	In progress	90%		100%		
Improved Discharge Communication/Information and Care across Transitions Phase I - Standardization of Discharge Planning Template (content): - Initiate project to develop standards of information to be provided to patients and their families upon discharge Phase II - Consider appropriate, potential role of LHIN in advancing medication reconciliation upon discharge. - Identification and standardization of core information to transition with patients from LTC, community care.	In progress	50%		65%		75%
Integrate Palliative Care Standardized care pathways and coordinated access and assessment opportunities identified and implementation plans created.	In progress	50%		50%		

and training opportunities for health care workers, a skills-building program for family caregivers, and tools to identify high-risk seniors.						
Plan developed to include other target populations in Behavioural Supports Strategy. MHA high-support housing and transitional supports targeting long-stay ALC population. Primarily focusing on adults with behavioural issues	In progress	100%				
Create permanent transitional high-support housing for people with severe mental health issue who are ALC. - The new capacity will create a total of 26 spaces for long stay patients with complex and challenging behaviours. - Launch 11 new high support units - Create 15 “step down” high support units for tenants ready to move to lower intensity of service. This “flow” will free up 15 spaces of high support. - Interdisciplinary Transitional Team (ITT) will support clients moving from hospital to housing, and from high support to step down. Over time, ITT would support other housing transitions. - Additional staff supports for transitioning patients and high support clients will be piloted. Additional short term staff resources may be brought on to support transition.	In progress	70%		30%		

How will we measure success?
The following indicators have been identified in the TC LHIN's 2013-2016 Integrated Health Services Plan (IHSP-3) to gauge the impact of these actions on patients and health system performance. The indicators will be revisited and potentially updated and associated targets will be developed later in 2013 to align with and support Health Links, the Seniors Strategy and any other new elements of the Ministry's health care transformation plan : <u>Indicators</u> Reduce the cost of services utilized by the 1% population. Reduced percentage avoidable unplanned hospital readmissions. Increased percentage of targeted complex patients in case management programs. Increased percentage in discharge planning summaries from hospital to primary care and CCAC within 48 hours. Reduced percentage of palliative patients dying in acute beds
What are the risks/barriers to successful implementation?
• Resolving privacy issues to allow for sharing discharge planning summaries electronically among providers and eventually to patients and caregivers. • Large amount of technical work in developing electronic discharge summaries in some hospitals. • Some primary care providers do not have EMRs, making electronic transmission of discharge information impossible. • If avoidable unplanned admissions are reduced immediately, data still will not reflect this for two years due to significant data lag for this indicator. • Availability of resources to support decanting of long stay ALC patients. • Resistance of care providers to support new models of care. • Current lack of capacity of community sector to support complexity of long-stay patients may slow decant and may require more or acceleration of initiatives to further integrate hospital and community sectors. • For mental health and addictions clients, availability of supportive housing at all levels, as well as lack of affordable housing, will slow attempts to facilitate movement of clients to right place of care.
What are some of the key enablers that would allow us to achieve our goal?
• Primary care provider adoption of EMR so that discharge summaries sent directly from hospital into EMRs for all primary care practice type for all patients. • Integrated teams to strengthen the clinical and non-clinical partnerships will help to support complex clients and to strengthen the overall program. • Mapping of current mental health housing capacity to serve complex clients will assist with identifying where capacity needs to be targeted. This would include defining "high support",

medium support” and “low support housing”, and building agreement on the core services and competencies required to meet needs at all support levels.

- Strengthening of data collection and analysis across the continuum.
- Reallocation of funding to follow the patient to the right place of care.

Integrated Health Services Priority:

Prevent and delay serious illness & injury among those who are at greatest risk of declining health – 5% of the population.

IHSP Priority Description:

The TC LHIN will focus on improving the care of the 5% of the population that accounts for over two-thirds of health care costs (hospital and home care) in the TC LHIN to improve their quality of care, outcomes, experience and to reduce the cost of their care. The LHIN will collaborate with the Ministry, ICES and others to undertake a thorough analysis of the sub-populations within the 5% high-needs, high-use group to create a profile of the populations. We will target initiatives to improve transitions, care coordination, access to appropriate levels of care and to enable more effective chronic disease prevention and management and self-care for people in their communities.

Current Status:

Profile, services and providers for the 5% population

5% of the population is at-risk of moving into the “1%” group. However, with the right supports and management their health care can be maintained and improved. Many of the people in this population group have multiple chronic diseases and require multiple services. They depend heavily on accessible primary care services and community supports.

Age

- 48.8% of the 5% are over the age of 65,
- 24.5 % are middle-aged (45-64 years old)
- 6.3% are under 1
- 7.4% are aged 1 to 17
- 13% are aged 18 to 44

83% of patients have been acute inpatients and 62% have used the ER.

Nearly 70% of seniors in the 5% group receive home care. Caregivers play an indispensable role in helping these individuals with their daily needs. Patient self-management programs can improve their health and quality of life.

- Mental Health and Addictions
 - The highest costs are associated with patients with serious mental illness and addictions. On average, per patient costs of mental health clients (\$78,500) followed by Complex Continuing Care (\$73,000).
 - Adults aged 18 to 44 use inpatient mental health and addictions services more than any other group (51.2% of use). Based on an analysis of the 10% of highest need/highest cost

- patients, almost 50% of patients had schizophrenia as their primary diagnosis.
- Mental health issues were also by far the main reason for ER visits by the 5% population.

- **Chronic Diseases**

- Heart and stroke conditions were the main reason for inpatient hospital stays among this group. This was followed by “blood and lymphatic system” conditions and respiratory conditions (e.g., COPD).

53% of patients in the 5% group come from other LHINs.

CRICH-ICES study involving the Toronto Central LHIN discovered that low income patients who tend to use local hospitals more for mental health services, are more likely to be ALC and are more likely to use the ER for non-urgent reasons.

Key issues

Long-stay ALC

Of those within this group who were admitted to hospital, 29% were designated Alternate Level of Care at some point during their stay and remained in hospital an average of 59.3 days – five times longer than the average person. This indicates that currently many are not receiving the supports they need and are not in the right place of care.

Patients who have been ALC for a long time (over 40 days) make up a large portion of total ALC in the TC LHIN. In September 2012, there were 296 “long-stay ALC” patients, an increase over September 2011.

Primary Care

Toronto Central LHIN has 1,820 family physicians, 13.9% of the province’s total. There are 15.8 family physicians per 100,000 people - the highest of any LHIN.

Despite the high number of family physicians, a considerable number are not working full-time on primary care and provide other types of medical services. Of note, 55% of patients who receive primary care in the TC LHIN live in other LHINs. As a result, primary care providers in Toronto have less availability to accept new local patients.

A significant number of people in the TC LHIN lack adequate access to primary care. The LHIN has the highest percentage of adults without family doctors. Some 25% of patients who visited TC LHIN ERs in 2011/12 did not have a primary care physician.

The LHIN also has the lowest rate of patients who are seeking primary care that were referred to a family physician using Ontario’s *Health Care Connect* program. There are several reasons for this. First, the high number of patients joining the program exceeds the number being attached to primary care in TC LHIN. The second factor is that some 50 % of TC LHIN physicians do not work in a group practice model and do not enroll patients. The last factor is that the “unattached” patients are more complex and practitioners who are not in a group practice report that they lack the resources to provide comprehensive care to these patients.

TC LHIN has the lowest percentage of patients who visit their family physician within seven days of discharge from hospital, as compared to other GTA LHINs and the provincial average.

Though improving, almost one third of ER visits in TC LHIN are rated as low priority CTAS 4 and 5 and could be seen in an alternate primary care setting.

Community sector

There is a great deal of fragmentation in the community sector today which makes it difficult for people to transition from hospital back home and to the community and to navigate community services. Targeted investments over the last five years to enhance the community sector's capacity have improved patient access in pockets, however significant gaps remain.

Data also indicate a likely mismatch between community need and the number, type and distribution of services across the LHIN. Individual agencies vary in their ability to demonstrate accountability and meet changing standards of patient care, such as the ability to send and receive patient information electronically and offer after-hours services.

Through community engagement efforts we have learned that Toronto residents are frustrated with gaps in community-based supports and are pointing to lack of continuity in the care they receive when they move between community agencies, primary care and hospital.

Successes last year

Primary Care Strategy

Over the past year, the TC LHIN led the development of a strategy for advancing primary care in the region.

The **initial phase** centred on an environmental scan to better understand the existing primary care landscape, and the many efforts underway to improve the system. The result of this work was the Summary of the Current State Scan Report [Continuing the Evolution of Primary Care in the Toronto Central LHIN: Our Starting Point](#). This critical work was informed by over 250 stakeholder consultations and guided by the Current State Task Group made up of system leaders in Primary Care.

In the **second phase**, we identified the vision and objectives of the Plan as well as the priority actions that would have the greatest impact on the local system and quality of care. A 35-person Design Task Group of primary care and other health experts supported this effort resulting in the identification of system-wide opportunities to strengthen primary care.

The LHIN used the information from the first two phases and a review of primary care in other Canadian and international jurisdictions to develop a Vision and Strategic Plan for primary care.

Vision

Providing personalized, seamless, timely, comprehensive, and high quality primary care to its population through collaboration across the system to advance improved patient outcomes and improved patient experience in the context of a sustainable health care system.

Toronto Central LHIN's Primary Care Think Tank in November 2012 brought together approximately 100 system leaders, family physicians and local residents to comment on the TC LHIN's plan for Primary Care Networks.

The TC LHIN proposed the creation of nine Patient Care Networks during local planning. The Networks have now become nine Health Links, in keeping with the provincial strategy. During December and Q4 2012-13, the TC LHIN worked with the three early adopted Health Links to develop

Business Plans, provided some key infrastructure and support to the Health Links, led outreach with providers in other Health Link areas and all TC LHIN sectors and other stakeholders in support of the planned implementation of Health Links. A web site for Health Links in the TC LHIN has been created to provide key information, tools in support of Health Links locally.

http://www.torontocentrallhin.on.ca/Page.aspx?id=7284&ekmensele2f22c9a_72_262_7284_19

Getting people to the right place of care; increasing care in the community

Alternate Level of Care - ALC

- In 2011/12, after steady improvements in the rate of patients who are designated ALC, the TC LHIN's ALC rates reached the lowest level since we actively started measuring this indicator. Despite increasing demand for TC LHIN acute hospital services last year, the LHIN met its ALC target of 10% in Q2 2011/12.

For Q1 2012/13 Toronto Central had the lowest ALC rate of all 14 LHINs.

Overall the number of people waiting in all TC LHIN hospitals for long-term care (LTC) has gone down 43% since fall 2009. Supporting seniors in their community and at home has resulted in a 56% reduction in the number of people who were ALC in acute care hospitals and waiting for LTC. There has been a 33% reduction in the number of people who were ALC in rehabilitation and complex continuing care hospitals waiting for LTC.

Programs such as *Home First* and *Virtual Ward* are allowing more seniors to receive health care where they live instead of automatically going to a long-term care home when their needs become more complex.

- Home First supports seniors to go home from hospital and has created capacity for those who need hospital care.
- 6400 seniors have benefitted from Toronto Central's Home First over the program's first 3.5 years
- We have made a 48% improvement in ALC-LTC freeing up 83,000 ALC days.
- Helped long stay patients in hospital get to the right place of care.
- Transitioned 134 patients that were in hospital for several years to more appropriate places.
- Supporting seniors better at home and reducing their visits to the Emergency Department.
- 4,500 ED visits and 650 admissions to hospitals avoided improving patient flow.
- Keeping more seniors home and out of long-term care.
- There are 300 fewer seniors applying for long-term care. In addition, 25% of seniors withdrew their long term care application because they felt they could stay at home.
- There are 2,000 more seniors linked to community supports

Supporting Caregivers

- The Toronto Central LHIN piloted the *Caregiver Framework for Seniors* project with the goal of easing the stress of caring for an ailing loved one. Informal caregivers were provided with funds and then they decided how to use these funds to help their loved ones and themselves. Over the course of the project, 300 caregivers were served. The majority of caregivers said they found the service very helpful and rated the program an average of 8.8 out of 10.

A similar project is underway through the Hospital for Sick Children for caregivers of medically complex children. As of early October 2012, 51 caregivers received support so that they were better able to provide care to their children.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal (s)

The TC LHIN's goal is to identify sub-populations within the 5% and to improve their access to an appropriate continuum of services with a focus on strengthening and integrating services and supports in the community – primary care and community-based services. As a result all clients will receive access to the services they need, close to where they live; have more personalized primary and community supports to manage their health; and effective pathways to specialized and acute care when they need it. People will be better informed, involved and able to influence their care.

Specifically, the TC LHIN will:

- Work with providers and researchers including Toronto Community Health Profile Partnership (TCHPP) and Institute for Clinical Evaluative Sciences -ICES/ Centre for Research on Inner City Health -CRICH collaboration to define **and understand the 5% population, their outcomes; their barriers and needs; and costs associated with their care. We will then focus those patients for whom we can make the greatest difference.**
- **Implement the Toronto Central LHIN's Primary Care Strategy to improve access to and integrate primary care in the continuum of care to improve people's quality of care and outcomes.**
- Establish Health Links in nine communities in TC LHIN. All providers in a sub-LHIN geographic area will work together to provide coordinated health care to patients – with the patient at the centre of that experience. Health Links will better and more quickly coordinate health care services for high-needs patients such as seniors and those with complex needs. The TC LHIN will begin with three early adopter Links – Don Valley/Greenwood, North East Toronto, and Mid West Toronto. They will start their journey by continuing to integrate primary care and CCAC services for the 5% of the population with the most complex problems.
- Enhance regional planning of diabetes programs and improve coordination of and access to evidence-based diabetes prevention and management programs delivered by the Diabetes Education Programs and through primary care in the LHINs within each Health Link.

Consistency with Government Priorities:

This aligns most with the Health Action Plan priority Right Care, Right Time, Right Place.

It also supports the government's priority - Faster Access and a Stronger Link to Family Health Care. This includes faster access to primary care; more ways to access family health care resources, such as telemedicine points of contact; and introduces quality measures to family health care as a key

component to have a fully integrated system.						
Action Plans/Interventions						
Action Plans		Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.				
		2013/14		2014/15		2015/16
		Status	%	Status	%	Status %
Create a detailed profile of the 5% high-needs population to understand the sub-populations and their specific needs, barriers, and costs and develop improvement strategies.		In progress	90%		10%	
Implementation of nine Health Links in TC LHIN sub-LHIN areas. - Early adopter Health Links business case developed and implementation of initial priorities begun. - Establish and prioritize targets for Health Links in TC LHIN. - All Health Links develop business cases. - All sectors phased into the Health Links - Planning has commenced		In progress				
		In progress	50%		50%	
		In progress	100%			
		In progress	100%			
		In progress	50%		25%	25%

Enhance regional planning of diabetes programs and improve coordination of and access to evidence-based diabetes prevention and management. - Assume operational mandate of the Diabetes Regional Coordinating Centre - Oversee planning of DEPs and all diabetes prevention and management	In progress In progress	100% 100%				
How will we measure success?						
We will know we have been successful if we can demonstrate we are raising the quality of care and reducing costs for the most complex, high needs patients. The system changes we are making for these patients will transform the quality of care for all patients. The following indicators have been identified in the TC LHIN's 2013-2016 Integrated Health Services Plan (IHSP-3) to gauge the impact of these actions on patients and health system performance. The indicators will be revisited and potentially updated and associated targets will be developed later in 2013 to align with and support Health Links, the Seniors Strategy and any other new elements of the Ministry's health care transformation plan : <u>Indicators</u> Reduce the cost of services utilized by the 5% population. Increased percentage of people in the target groups with primary care provider. Increased percentage of people see primary care provider within 48 hours of discharge from hospital. Reduced percentage repeat unscheduled ED visits.						
What are the risks/barriers to successful implementation?						
- High degree of fragmentation of primary care and number of solo practitioners makes it difficult to engage all primary care physicians and practice types and to link them with other providers. - Fragmentation and high degree of variability in the capacity, services of the community sectors – community support services and mental health and addictions – makes collaboration and coordination a challenge.						

Complexity of initiative is such that may take several years to see demonstrable impact on health system performance data and overall system costs.
What are some of the key enablers that would allow us to achieve our goal?
- High quality data packages for planning at the sub-LHIN level. - Full implementation of the Integrated Decision Support System to proactively identify High Users - Strong leadership in the founding Health Links. - Sector leaders and champions. - Strong inter and cross-sector partnerships across the care continuum at LHIN and sub-LHIN levels. - Effective primary care, health provider and patient/community engagement at the local level. - Effective, clear and continuous communications to support the change management process for primary care integration and Health Links. - Effective performance measurement and reporting mechanisms. - Mechanisms for cross-LHIN planning and coordination. - Leveraging existing capacity and high performing initiatives.

Integrated Health Services Priority:
Improve the patient experience.
IHSP Priority Description:
The only way we can design a health system based on patients' needs is to understand their experience in the health care system through meaningful and continuous measurement and by hearing directly from all types of people about what they need for their health and wellbeing. We aim to improve the patient experience by having all health service providers begin to systematically measure and report on how they are improving the patient's experience. Patient input is an integral part of all the initiatives that the TC LHIN leads and funds. As part of this, we will focus on developing and implementing community engagement strategies to include the voices of those in our community with the greatest needs who, all too often, are not well served or heard in the health system. Information from these communities will be used by the TC LHIN for health system planning and provided to providers to inform service planning and integration at the local level.
Current Status:
Situation – populations and services The LHIN's role is to understand the client's and patient's holistic experience across the system. Effective patient and community engagement is an integral part of creating a patient-centred system.

By making the patient experience the barometer for quality health care and by treating patients and caregivers as partners, we will transform the health care system and the health of those who depend upon it.

Aging in the City

It is estimated that 32% of the population is 22 to 44 years old and 14% of the population aged 65 years and older. By 2016, seniors will account for 14.8% of the LHIN's population. The Baby Boomers are reaching an age where they will need more health care. The majority of people who are ALC in a hospital are over 75. Similarly, seniors visit ERs more than the rest of the population in the TC LHIN.

Aboriginal Peoples

According to the 2006 Census, the city is also home to 16,200 Aboriginal people, one of the largest Aboriginal populations in Canada. Toronto's highly diverse Aboriginal community is made up of many different First Nations and communities from across the country.

Aboriginal communities have significant health disparities and have been historically marginalized within the mainstream system. Aboriginal people in the city are, on the whole, in poorer health than the population generally. For example, diabetes in the Aboriginal communities is three to five times higher.

There is, however, limited reliable information about the health status and health care use of Aboriginal peoples due to the fact that Aboriginal ethnicity is not flagged in health administrative datasets such as ICES.

The Francophone Community

Toronto has a substantial Francophone population of 53,000 (9.2% of Ontario's Francophone population) many of whom are recent immigrants and/or are visible minorities.

Francophones are increasingly diverse with 49.8 % born outside of Canada and a high proportion of recent immigrants, largely from African countries. Francophones are dispersed across the city and do not tend to live in any particular neighbourhoods. Likewise, French language health services are scattered across the TC LHIN which contributes to challenges navigating health care.

Serving an Immigrant Population

In TC LHIN 41% of residents are immigrants, 8.3% of whom arrived in Canada between 2001 and 2006. Newcomers face barriers to care, particularly if they don't speak English.

Some 170 languages and dialects are spoken in Toronto. Today, 4.5% of the population reports no knowledge of either official language.

Evidence shows that people with limited proficiency in English stay longer in hospital when they are unable to communicate in their chosen language. Conversely, the quality of care increases when a patient is able to communicate in their first language.

Key issues

While efforts are underway to measure “the patient experience,” they tend to be focused on care within a specific institution, primarily hospitals. Currently, patient experience measurement is inconsistent, often insufficient, and not always meaningful or visible beyond senior management and Board. Public reporting is frequently focused on “satisfaction measures” such as “would you recommend this hospital to a friend?” that do not capture a patient’s experience or have the potential to drive meaningful change.

Furthermore, measurement of patient experience is typically limited to English and French when nearly half of Toronto residents have a first language other than the two official languages.

Patients who are engaged in their care have better health outcomes and experiences.

Despite our best intentions, however, some groups’ views are largely absent from health care planning. The input the health system receives tends to reflect the experience of socially and economically advantaged groups. Populations who do not fit into conventional methods of public engagement are excluded from conversations about health care. As a result, the established processes do not capture a diversity of patient experiences.

Populations such as Aboriginal people and Francophones and newcomers face additional barriers to care when they do not receive culturally competent services in their first language. Lack of culturally based and responsive care contributes to Aboriginal people and other populations avoiding care, having a poor experiences, and poor health outcomes.

Successes last year

In 2012/13, TC LHIN conducted an in-depth analysis of patient engagement measurement across its HSPs, conducted over 45 interviews and obtaining measurement tools from more than 30 providers. In addition, consultations have been done with Health Quality Ontario, Ministry, Cancer Care Ontario, and The Change Foundation. The result has been the identification of existing and best practices in measuring patient experience and potential domains for standardizing questions. The LHIN has also funded St Joseph’s Health Centre to trial an electronic patient experience measurement tool, in partnership with other HSPs.

Community Engagement

- TC LHIN together United Way, Toronto Community Housing, the City of Toronto and St. Michael’s are developing common plan to improve health access in St James Town and address the access issues exposed by the 2010 200 Wellesley Street fire. The project got off the ground in 2012. The diverse communities that make up this neighbourhood are integral to every step of the plan. Community animators drawn from different ethnocultural, linguistic and other identified communities including Lesbian Gay Bisexual and Transgendered and youth sought input from their communities and a series of community meetings in multiple languages are being undertaken.

In a recent survey, 17% of St. James Town residents said access to a General Practitioner (GP) is an issue. Immigrants are more likely to see multiple providers (66.6%); more likely to use walk-in clinics (54.9%); and more likely to wait to get a primary care appointment. However, most people report some form of difficulty with communications with a health professional.

The model that emerged is a single gateway to services that St. James Town residents need. A number of services and initiatives are being put in place. 1) a Mobile Dental Bus, a partnership between Toronto Public Health, Toronto Community Housing, Community Corner and Community Matters in St. James Town and 2) Senior Mental Health Day Program, a collaboration among seven local agencies and Toronto Public Health, and 3) Toronto CCCAC Neighbourhood Care Teams.

Culturally Competent Care

As part of the TC LHIN's Health Equity Action Plan, the TC LHIN launched *Language Services Toronto* in 2012, a shared telephone interpretation service offering 170 languages that is allowing people with language barriers to communicate with their physicians, nurses and other professionals.

- The TC LHIN brought together hospitals to bulk purchase telephone interpretation services in order to increase access to the service while reducing the cost to hospital and community agencies. Hospitals will see their phone interpretation rates decrease by up to 80%. With much lower rates, the Toronto Central LHIN is funding local community agencies to join starting in 2012.
- As of fall 2012, 35 GTA hospitals and community agencies and one from Waterloo Wellington LHIN are able to offer this phone interpretation service to patients.

The Toronto Central LHIN has developed a partnership with Anishnawbe Health Toronto and the Ontario Federation of Indian Friendship Centres (OFIFC) to deliver cultural competency workshops for front-line staff at provider organizations. Mental Health and Addictions agency staff and executive directors received cultural competency training in 2012/13.

A pilot project led by an Aboriginal research team and supported by Anishnawbe Health Toronto and the TC LHIN produced the *Urban Aboriginal Diabetes Research Project Report*. This groundbreaking publication highlighted the need for a new model of culturally-based, community care and diabetes prevention strategies for the at-risk Aboriginals.

Through a community-led process TC LHIN invested in innovative programs with Aboriginal agencies with mental health and addictions agencies partnering to deliver enhanced services to support Aboriginal youth experiencing mental health and addictions. An Aboriginal community and Aboriginal Youth engagement process shaped the principles and priorities for the selected initiatives. Implementation began in 2012.

1. *"Eshkiniigjik Naandwechigegamig – A Place for Healing Our Youth"* - Native Canadian Centre of Toronto, in partnership with Madison Community Services, the Central Toronto Community Health Centre and Noojimawin Health Authority.
2. *"Serving Aboriginal transitional aged youth with mental health and addictions issues: A cross-sectoral, community model"* – LOFT Community Services, in partnership with Native Child and Family Services Toronto, The Centre for Addiction and Mental Health, and Boundless Adventures.

Francophone engagement

The French Language Health Services Entity for Toronto Central, Central West and Mississauga Halton LHINs - Reflet Salvéo – plays an important role in making sure that Francophones have an effective voice in health care planning.

Reflet Salvéo has submitted two annual advisory reports on FLS services in the 3 LHINs as well as special reports on HIV/AIDs services and mental health and addictions services for Francophone youth. The information and advice from evidence, analysis and consultations with different Francophone groups is incorporated into the TC LHIN's system planning efforts. The three LHINs are mapping health care services, needs and gaps so that, starting in 2013, we have evidence about the mix of services available, needs and gaps for this unique community.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goals

- All TC LHIN funded health service providers will begin to measure and report on how they are improving the patient's experience with health care.
- We are developing an ongoing process to engage people who face barriers and then develop reports based on their input that we will use for system and health service planning. For each of the next three years we will target different communities, and develop customized strategies and techniques to engage them.

Through these efforts we will have a more inclusive and accurate view about people's experiences in TC LHIN's health care system.

- Using the French Language Services map and input from Francophone communities, particularly those who are underserved and have high needs, we will support strategies to address pressing health care gaps.

All health service providers serving Francophones will have plans to continually improve services to this community. Progress on these plans will be reported to the LHIN starting and, in time, to the public.

- We will improve the experience of people Aboriginal people receiving services in TC LHIN with a focus on with Aboriginal youth and Aboriginal people with mental health and addictions issues. This will reduce reliance on emergency services and hospitals for basic health care needs.

We will create lasting capacity within the system to provide new staff entering the workforce with the knowledge and skills to deliver culturally competent care to Aboriginal peoples.

- We will improve care coordination and navigation for medically complex children and their families with a focus on children and families who face socio-economic and linguistic barriers and

transitions from the pediatric to the adult system.						
Alignment with government priorities						
This aligns most with the Health Action Plan priority Right Care, Right Time, Right Place.						
Action Plans/Interventions						
Action Plans		Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.				
		2013/14		2014/15		2015/16
		Status	%	Status	%	Status %
Measure, Report on and Improve the Patient Experience • Work with patients and providers to determine meaningful measures of the patient experience. Conduct literature review regarding best practices, analyze data. • Recommend a minimum set of questions across the continuum of care. • Work with providers to bulk purchase or create standard measurement tool.		In progress	50%		75%	100%
Engaging Patients in their Care • Patient Destiny create a report on engagement of Mount Dennis community members and patients to be used by TC LHIN for health system design and planning and provided broadly to health service providers		In progress	100%			
		Not started	100%			

• Evaluate process and select next populations/communities and project(s) • Undertake targeted community and patient engagement processes with additional populations – geographic, ethnocultural and other. • Community engagement reports provided to LHIN, HSPs, stakeholders.	yet					
	Not started yet	100%				
	Not started yet	100%				
	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Improve culturally competent care In response to recommendations of TC LHIN Advisory Table for Children and Youth the improve quality of care and experience of medically complex children, youth and their families. • Improve access to information about health care resources and services for children/youth and their families facing socio-economic and ethnocultural/ linguistic barriers; • Enhance care coordination and system navigation for children with medical complexity; • Improve transitions from the paediatric to adult health system for the spina bifida population. • Implement caregiver for children initiative to reduce stress on and provide customized supports to caregivers of medically complex children.	Not started yet	100%				
	Not started yet	75%		25%		
	Not started yet	100%				
	In progress	100%				

Improve culturally competent care • Set priorities for addressing Francophone health service gaps and needs based on service map and outcomes of community engagement, in alignment with IHSP-3 priorities and Health Links. • All health service providers serving Francophones have plans to continually improve FLS services. • Report on progress on these plans will be reported to the LHIN starting in summer 2014. • Work with HSPs to integrate and share services and resources in order to improve access to culturally and linguistically appropriate services to Francophones.	In progress	50%		25%		25%
		100%		100%		
		25%		50%		25%

How will we measure success?

The outcome of this Strategic Priority is that all HSPs within TC LHIN measure meaningful information about the patient experience beyond patient satisfaction. In the longer term, this information will be reported publicly and used by providers in their quality improvement processes. Patient experience will be measured in multiple languages.

We will also know we are successful if people have an effective voice in health system design and delivery in the TC LHIN and we become more knowledgeable about the needs and preferences of those facing social, cultural and economic obstacles.

The following indicators have been identified in the TC LHIN's 2013-2016 Integrated Health Services Plan (IHSP-3) to gauge the impact of these actions on patients and health system performance. The indicators will be revisited and potentially updated and associated targets will be developed later in 2013 to align with and support Health Links, the Seniors Strategy and any other new elements of the Ministry's health care transformation plan :

Indicators

Increase in TC LHIN providers' patient experience scores.

Standardize patient experience measurement tools used by health service providers.

What are the risks/barriers to successful implementation?
<u>Patient Experience measurement</u> • Current methods of measuring patient experience are very expensive. Expanding them to cover more languages or more people surveyed will be costly. For our smaller agencies to begin measuring, the costs may be prohibitive. • Many HSPs are in contracts with vendors (e.g., all hospitals and CCAC) conducting patient experience measurement. Changes to the tool would be unwieldy. • Perception of privacy concerns may constrain rollout of electronic measurement tool. <u>Patient engagement</u> • Significant time and resources required to reach and meaningfully engage certain populations – e.g., those with language and cognitive barriers, homeless, homebound and isolated seniors. <u>Aboriginal cultural competency</u> • Risk of low participation and support by HSP leadership in cultural competency training. • Risk of sustainability due to Aboriginal agency capacity to provide ongoing training to HSP staff in culturally competent care. <u>Francophone cultural competent services</u> • Limited French speaking human resources in key specialties and service areas to provide active offer. • Limited resources of community agencies to increase translation and in-person interpretation. <u>Children and Youth quality and access to care</u> • Risk of low participation and support by HSP leadership
What are some of the key enablers that would allow us to achieve our goal?
Public reporting of patient experience measures and inclusion in accountability agreements. Ministry/OHA funding for translating the NRC Picker patient satisfaction survey into Top 10 languages spoken in Ontario. HSP leadership and commitment to patient engagement and cultural competency.

Integrated Health Services Priority:
Deliver value and sustainability through efficient use of resources.
IHSP Priority Description:

The key to curbing the overall cost of health care is improving quality. High quality, care ultimately costs less. This priority is about making existing resources in the LHIN go further to deliver higher quality at the same or better cost. This priority also takes aim at unnecessary costs and inefficiency.

While many health service providers in the LHIN have been able to make their operations more efficient, there are diminishing returns by seeking efficiencies in silos. The real gains exist at the system level by supporting patients as they transition from service to service, by taking a holistic view of people's health and by redirecting resources from areas that are not producing value into services that will have the greatest impact on health outcomes.

We will focus on two areas.

- Strengthening the capacity of community health sectors to respond to the needs of an increasingly complex group of clients who are living longer and who want to be as active and self-reliant as possible.
- The second focus is on better integrating key clinical services in order to improve patient outcomes at the same or lower cost.

Current Status:

Population and services

We are already experiencing a rise in the proportion of seniors and those living with chronic diseases who require – and expect – to be able to live and receive care in their communities for as long as they are able.

33% of Toronto Central residents (aged 12+) have a chronic condition and 14% have multiple conditions and require strong primary care and community care systems that are well integrated within the care continuum. Chronic conditions account for 6 out of 10 deaths and a quarter of the days spent in hospital in the TC LHIN.

TC LHIN Community Services

There are a significant number of community health providers in the TC LHIN and a high degree of variability and inconsistency in their services. Currently we do not know the nature of HSP service boundaries and where there might be service gaps geographically and for specific populations. Community services are generally disconnected from the primary care system and transitions in and out of the community and among community services are where many quality issues arise.

150 Community Health Service Providers (HSPs)

- **1 Community Care Access Centre (CCAC)**
 - ✓ 761,889 visits and 2,626,249 hours (2010/11)
- **17 Community Health Centres (CHC)**
 - ✓ Other Primary Care Providers (~1,600 family physicians, ~3,500 specialists)
- **68 Community Support Services (CSS)**
 - ✓ 150,084 individuals served, (52% 65+ years)
- **69 Community Mental Health and Addictions Agencies (CMHA)** 116,734 individuals served)

There is significant variation in the type and amount of funding for community supports. As well, the majority of community-based HSPs receive funding from a variety of sources. Community support and mental health and addictions agency budgets range between \$100 to \$400,000 (total LHIN and non-LHIN funding) to over 1 agency with a budget of over \$30 M.

TC CCAC

Increasingly the TC CCAC is focusing on the most complex clients who require case management to coordinate the multiple services they require.

The TC CCAC provides specialized support and care coordination to the following populations: children who have complex medical needs.; homeless, under-housed, those with cognitive impairment and mental health issues; frail seniors; and adults with long-term conditions and their caregivers.

In 2010/11, TC LHIN had the largest number of active home care clients (91,682) compared to all LHINs. Similar to all LHINs, the largest rate of home care clients was in the 85 and older age group.

The number of home care clients in the LHIN increased by 85.3% between 2007/08 and 2010/11. The largest increase was seen in clients under the age of 18 (98.6% increase) followed by those over the age of 85 (95.8% increase).

Compared with Ontario, the rates per 1,000 population for home care service visits (665.2) and for home care service hours (2,292.8) were higher in Toronto Central LHIN.

In Q4 2011/12, TC LHIN's 90th percentile wait-time for home care services above the Ministry LHIN Performance Agreement (MLPA) target at 42 days. The wait for clients coming from hospital was considerably less at 11 days.

Clinical services

In 2011/12, there were 525,026 ED visits to Toronto Central LHIN hospitals and 35.6% of these visits were by residents of other LHINs. Between 2007/08 and 2011/12, there was 16.8% growth in ED visits to Toronto Central LHIN compared to a 8.7% growth for Ontario.

A number of hospitals in the Toronto Central LHIN provide specialized services not offered anywhere else while also training future health care providers and conducting research.

In Q4 2011/12, TC LHIN's 90th percentile wait-time for home care services above the Ministry LHIN Performance Agreement (MLPA) target at 42 days. The wait for clients coming from hospital was considerably less at 11 days.

Some TC LHIN hospitals provide specialized services not offered elsewhere in the province. More than half the patients in local hospitals are from out of town, and 41% of ALC patients discharged from city hospitals live in other LHINs.

- TC LHIN serves residents across the province; 52-53% of TC LHIN super high and very high users of health care resources were from other LHINs

- Out-of-LHIN patients were more expensive in the 1% group (\$182,500) and approximately the same as the LHIN population for the 5% (\$71,000)

Stroke and MSK.

- In 2010/11, TC LHIN acute care hospitals performed 4,577 total joint replacements, 34% of these patients were discharged to inpatient rehabilitation. As can be seen the 2010/11 TC LHIN annual primary TJR inpatient rehabilitation case volumes ranged from 11 at Baycrest to 448 at Sunnybrook. The average inpatient rehabilitation Length of Stay (LOS) for primary joint replacement cases varies from 4.9 days at Sunnybrook to 27.3 days at Baycrest.

In 2010/11 there were 1,031 adult hip fractures treated in TC LHIN acute care hospitals. The acute length of stay (LOS) for adult patients ranged from 8.7 days to 14.2 days. The average number of days spent waiting for an alternative level of care ranged from 2.4 days to 6.9 days. There was a similarly wide variation in the intensity/complexity of care requirements for these patients ranging from a low Resource Intensity Weight (RIW) per case of 2.28 to a high of 3.61

- Heart disease (including ischemic heart disease (IHD) and congestive heart failure (CHF) and stroke account for 11% of all hospital days and 8% of all acute care separations for LHIN residents

In 2010 there were 2,259 adult stroke patients treated in TC LHIN acute care hospitals. The acute ALOS for adult stroke patients ranged from 9.2 to 11.1 days. The average number of days spent in acute care waiting for an alternate level of care ranged from 1.5 to 14.1 days. There was a similarly wide variation in the average intensity/complexity of care for stroke patients.

Issues

Community sector capacity

Toronto residents are expressing frustration with gaps in community-based supports and are pointing to lack of continuity in the care they receive when they move between community agencies, primary care and hospital.

Other factors affecting the pace and success of change are:

- Community HSPs grew out of diverse grassroots movements
 - There is a lot of history and community investment in these organizations, such as strong local relationships, boards and volunteer bases. With this comes significant risk in disrupting/making change to existing and often entrenched structures.
- Community HSP capacity and capabilities are wide-ranging
 - There are substantial variation in the size, structure, scope and services provided by community HSPs
 - Although we are aware where agencies are physically located, we do not yet know the whether the services they provide within their catchment areas provide coverage for all sub-LHINs. This makes it difficult to know whether we have an adequate or appropriate mix of services in the right areas to meet patient needs.

Community HSPs have varied funding and financial structures

- For most community agencies, the LHIN is not the only and/or primary source of funding Because

of this, it is more challenging to influence change management efforts.

- Community HSPs have high administrative and reporting burdens and lack data standards and structures to monitor activity and performance.

Clinical services

There are a number of clinical areas where there are opportunities to improve evidence-based practice, patient outcomes and value for investment through changing models of care and integration.

There are known gaps between the evidence-based clinical best practices and performance that could be addressed through collaboration and integrating care pathways and services.

- Despite having excellent clinicians and stroke programs, TC LHIN had not been meeting best practices for stroke rehabilitation.

Stroke patients discharged for intensive inpatient rehabilitation within 5-7 days have a better prognosis than those who stay in hospital longer. The average length of stay for stroke patients in TC LHIN hospitals was 10.8 days.

The Ontario Stroke Network annual report cards indicated significant opportunities to improve stroke care in the LHIN including:

- Consolidation of acute stroke programs to create a critical mass of expertise in certain hospitals.
 - Referring and admitting stroke patients to inpatient rehab earlier.
 - Providing more patients with severe strokes with high-intensity rehab instead of low intensity programs
 - Redirecting patients with mild stroke to outpatient rehabilitation programs after acute discharge.
- While individual hospitals were providing top notch hip and knee surgery, they were not meeting leading practices. Patients were remaining in hospital when they could be transferred to rehabilitation earlier. The TC LHIN initiated a solution with hospitals to redesign hip and knee replacement rehabilitation in Toronto.

Unmanaged wound care is enormously expensive, costing TC LHIN an estimated \$74 million a year. The Canadian Association of Wound Care (CAWC) contends that not only is Ontario (and TC LHIN) spending more than it should, it is also purchasing lower quality care. CAWC cites a study comparing a best practice-based approach versus a standard community care approach where the former has significantly faster healing over a four week period (50% healing versus 12% for diabetic foot ulcer and 42% versus 26% in leg ulcers).

Without a system-wide solution, TC LHIN providers are missing out on the opportunity to take advantage of supply chain efficiencies on the expensive wound care materials.

In addition, HSPs do not have an information system to track wound care patients in order to assess the current state or to guide system redesign.

Quality Based Procedures (QBPs)

QBP's will create incentives for hospitals that have not yet implemented best practices for total joint replacement, hip fractures and stroke. At this time the funding model has created unintended consequences for Toronto hospitals that have already made changes to conform with best practice guidelines prior to HSFR implementation. The TC LHIN's Health System Funding Reform (HSFR) Advisory Committee is discussing ways to mitigate and address these impacts.

Successes this past year

Harnessing electronic health care

Ehealth plays a pivotal role in patient care, safety and access. The ehealth landscape in the TC LHIN is extremely complex, comprised of several large-scale, high investment solutions. As such, HSPs benefit from the coordination and direction provided by the LHIN and eHealth Ontario to create an integrated and effective eHealth environment.

To date, eHealth Ontario has supported the LHINs in the form of one-time funds to operate an ehealth Project Management Office model. These funds have allowed the LHINs to work directly with HSPs, other LHINs and ehealth Ontario to drive provincial and regional projects while leveraging the strength in understanding the unique features of each local environment. This support has been instrumental in achieving the successes of many key initiatives, including the TC LHIN's RM&R project, which has become one of the fastest growing and most coordinated ehealth initiatives in Ontario.

Resource Matching and Referral (RM&R)

Health care organizations across the continuum of care are using one system to match and refer patients to services that meet their needs, faster. Today in TC LHIN, over 84 health service providers use RM&R to support patients transitioning from hospital to rehabilitation, community and long-term care. So far over 75,000 patients have been supported by RM&R.

Toronto Central LHIN is also the sponsor for the Provincial Alternate Level of Care RM&R Business Transformation Initiative (ALC RM&R BTI) which aims to standardize referral processes and forms across the province,

TC LHIN is part of Cluster 2, which includes Central West, Mississauga Halton, Toronto Central, Central, Central East, and North Simcoe Muskoka LHINs. The clustered 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. As the sponsor, the LHIN is also working closely with the Ministry to ensure alignment with recommendations from the Seniors Care Strategy and to explore options for an automated RM&R solution.

TC LHIN is a key partner in **ConnectingGTA (cGTA)** will remove barriers to electronic information exchange to provide seamless and secure access to patient information. ConnectingGTA will integrate electronic patient information from across the care continuum and make it available at the point-of-care to improve the patient and clinician experience. Starting with clinician-identified priority data, the project will leverage local, regional and provincial eHealth registries and repositories as data sources for clinical reports (CCAC, discharge summaries, emergency department, visits & encounters), diagnostic imaging reports, drug information and lab results.

The Diagnostic Imaging Repository (DI-r) will store and support sharing of diagnostic images locally, regionally, provincially and on a pan-Canadian basis. The creation of a diagnostic imaging repository is a critical component of an 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 across TC and GTA LHINs providing some 10,000 clinicians with access to patients' full, longitudinal DI history.

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

Strengthening IM/IT Capacity in the Community Sector (Community Information Infrastructure & Community Business Intelligence)

The Toronto Central LHIN conducted a comprehensive assessment of the IM/IT environment of all TC LHIN community-based providers in early 2011. Recommendations include specific low-cost, high-impact opportunities to improve efficiencies in IM/IT procurement. This will help to further integration and capacity within the community sector.

By end of 2012/13, the following should be completed:

- A process developed for bulk purchasing of IT hardware and devices.
- Engagement of CMHA and CSS HSPs to develop requirements for a common client management system (CMS) and shared IT services model.
- Early adopters identified to pilot the submission of community data fields to data repository.
- Establishing partnerships to leverage existing data repository and business intelligence capabilities for community sector information.

The focus of 2013/14 will be conducting an RFP for a common (CMS) and shared IT services model for CSS and CMHA and increase the number of community HSPs submitting standard information into the identified data repository.

Integrated Decision Support (IDS) Tool is a secure web-based business intelligence tool that has been in use in the HNHB LHIN. Hamilton Health Sciences (HHS) will extend IDS to the TC LHIN office, hospitals and CCAC to allow us to analyze de-identified patient journeys across multiple episodes. This will support system planning and quality improvement and enhance our understanding of the 1% and 5% populations. It is expected that all participants will sign the Data Sharing Agreement by the end of 2012-13.

Improving the pathway to clinical services

Dr. Barry McLellan, CEO, Sunnybrook Health Sciences Centre and Marian Walsh, CEO, Bridgepoint Health are spearheading the implementation of a new model for the delivery of stroke and orthopedic care (total hip and knee replacement and hip fractures) that will improve quality of care and make better use of resources.

Better Stroke Care through System Action

Generally stroke patients in the TCLHIN need to move from acute hospitals to rehabilitation sooner. More patients need to have access to rehabilitation and rehabilitation services need to be resourced to deliver the best practice care in both inpatient and outpatient settings. The result is a system that delivers best practice, quality stroke care at a lower cost.

So far, stroke services have been expanded where they are needed. There is an agreement to consolidate and shift resources from Mount Sinai and Toronto General to Toronto Western to create a critical mass of expertise at that hospital site. Instead of going to Mount Sinai and Toronto General Stroke, patients will now be taken to Toronto Western.

Better Hip and Knee Rehabilitation through System Action

As part of the stroke and hip and knee best practices initiative, hospitals and community agencies, primary care and others are working together to increase access to timely rehabilitation services outside of hospitals. Patients will receive the same high quality outcomes, at a lower cost.

Substantial improvements have already been achieved:

- Outpatient services are being enhanced in a number of organizations. The number of hip and knee replacement patients discharged home increased from 64% in 2010/11 to 81% by fall 2012.
- GTA and North Simcoe Muskoka LHIN hospitals are participating in this new model and achieving similar improvements.

A full plan for redesigning stroke and orthopedic rehabilitation services will begin implementation in 12/13 and be completed in 13/14.

Integration through System Action

In the past few years, TC LHIN providers are integrating in different ways to improve quality of care, expand services, and manage rising costs.

There are different types of integrations underway including share services, consolidations of back office services and clinical collaborations. There have also been a number of large-scale mergers in our LHIN including UHN and Toronto Rehab, Sunnybrook and St. John's Rehab, and WoodGreen and Community Care East York – the largest amalgamation of two community health agencies.

On the whole, these integrations are working well for patients and for the system. They are resulting in better patient care at the same or lower costs. Here are highlights over the past year:

UHN –Toronto Rehab Merger

This merger has already saved over \$3 M which is being reinvested in services including rehab for older people with hip fractures.

This new model of care is resulting in patients (stroke, spinal cord injuries, hip and knee replacement) getting into rehab earlier and recovering at home sooner. UHN has been able to reinvest savings in

expanding the hospital's fast-track stroke clinic.

Staff and patient satisfaction at the hospital has been maintained and improved in some areas.

Women's College Hospital's New Model of Care

Women's College Hospital is transforming its model of care, shifting away from their Urgent Care Centre model to expand ambulatory services for people with complex chronic diseases.

This hospital is expanding its Acute Ambulatory Centre that provides urgent and short-term care to people with chronic diseases including congestive heart failure, asthma, and diabetes. Women's College is also providing transfusions to cancer patients in partnership with Princess Margaret Hospital.

Women's College also has innovative projects to support family physicians including "Navigation hub" –where a nurse and CCAC coordinator helps family physicians to connect to specialists, diagnostic testing and community resources and "Internist on call" - that assists family physicians with complicated patient issues.

A Virtual Ward for mental health and addictions patients (PsychSTEP) has been designed to keep high-risk patients out of hospital by providing them with fast access to an interdisciplinary team through a single point of contact.

These programs will be leveraged by the Mid-West Toronto Health Link

WoodGreen and Community Care East York Merger

A year after its merger with Community Care East York, WoodGreen is providing seniors, people with disabilities, immigrants and others with more services within the same overall budget.

- Case management/ counselling have increased by 10%;
- Social Recreational Programs have increased by 25%;
- Social & Congregate Dining has increased by 20%;
- Volunteer services are up by 30%.

Providence Health Care – Transformation by Design

Providence has been integrating services with other hospitals and CCAC in order to support patients to get patients into rehabilitation and home sooner and safely.

The model started with stroke rehabilitation and Providence is now reducing the number of beds in all its inpatient units and reinvesting these resources to support on-unit rehabilitation and onsite outpatient services.

Providence nurses are working inside acute care hospitals to support patients to transition to rehabilitation earlier. Providence's staff stays in touch with patients after they leave, make home visits

and provide outpatient support to clients discharged to the CCAC.

Results within the first few years:

- A steadily increasing number of patients admitted to Providence programs with fewer beds.
- More than 300 additional patients per year are going home with the right level of support compared to 2009/10.
- Stroke/neuro patients are getting home sooner without compromising clinical outcomes.

Improving efficiency and outcomes of cataract surgery

Academic Health Sciences Centres in the TC LHIN had been delivering routine cataracts when they could be done more efficiently and faster in centres of excellence like Kensington Eye Institute. Under the leadership of the TC LHIN, the local health system has reorganized the delivery of cataract surgery. All routine cataract surgeries are being done by Kensington Eye Institute, a recognized centre for excellence for high quality, cost-effective cataract surgery. Academic Health Sciences Centres are now able to direct more of their resources to complex eye surgeries, reducing wait times for patients.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal (s)

Strengthening Community Capacity

- To improve client access to right care at the right place and time.
- To improve the client experience.
- To reduce avoidable costs by supporting people at homes and in their communities and reducing hospital and institutional care wherever appropriate.

To achieve these goals, services provided by mental health and addictions agencies, community support services and CCACs need to be linked with primary care services within the TC LHIN's Health Links.

Improving quality of care and costs through clinical integration

Redesign the way clinical services are delivered between hospitals, CCAC, community agencies and other provider so that:

- More patients will receive the most appropriate rehabilitation care following a stroke, hip and knee replacement surgery and hip fracture according to their needs.
- Wound care patients will have a better experience and better outcomes as a result of a plan to prevent avoidable wounds and more effectively manage those that cannot be prevented.

These and other clinical integrations identified by providers and clinical leaders will reduce duplication of specialized clinical services, and allow hospitals to concentrate on their core services while creating a critical mass of expertise in the city's health care system.

Action Plans/Interventions

This aligns most with the Health Action Plan priority Right Care, Right Time, Right Place.

It also fully supports the Excellent Care for All strategy and the specific goals of a higher standard and more efficient care for all.

Action Plans	Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
Building community sector capacity						
- Invest any ongoing or one-time funding in services that address identified service gaps for target high needs populations in the community, includes: - Continue to invest in the transfer of lower acuity clients from CCAC to CSS - Expanding enhanced adult day programs and Assisted Living Services for High Risk Seniors across the TC LHIN	In progress	60%		20%		20%
Integrated Community transportation plan - Plan, in collaboration with the United Way, for the functionality of a community transportation system that serves the needs of the 5% population	Not started yet	100%				

• Attendant Care Coordinated Access Hub ○ Define processes and protocols for waitlist management and hub development ○ Implement Coordinated Access Hub ○ Evaluate Access Hub	In progress	70%		30%		
• Community Information Infrastructure Program (CMHA & CSS) ○ Support purchase of IM/IT systems and services; and non-IT equipment through central purchasing. ○ Procure a common client management system and/or IT shared services support so HSPs can better coordinate client care within and across agencies. ○ Include community sector information in “business intelligence information systems” so we have the ability to track and evaluate patient care across their entire health care journey.	In progress	100%				
	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
• Planning to incorporate community-based services into Health Links.	In progress	50%		50%		
Long-term LTC sector design.	In progress	100%				
Implement future state model for stroke care.	In progress	90%		10%		
• Implement new model of stroke						

care across all Toronto hospitals and the GTA, including changes to “patient repatriation” protocols.						
Resources redirected to support the best model of care including a reinvestment in inpatient rehabilitation and community based services through the TC CCAC.	In progress	50%		50%		
Evaluate progress	In progress	50%		50%		
Implement future state model for total joint replacement and hip fractures	See below					
Determine institutional implications of and resources required to fully operationalize these new care models.	In progress	75%		25%		
Create evaluation and sustainability plan	In progress	50%		50%		
Full HSP adoption of best practices - Total joint replacement best practices - Hip replacement	In progress In progress	90% 50%		10% 50%		
Improving wound care through system action						
Create a new model for delivering wound care best practices across all sectors in the TC LHIN and then the GTA.	In progress	100%				
Strengthen specialized and ambulatory services.	In progress	20%		70%		10%
Create a robust system to measure performance within organizations and the LHIN overall and for different groups of patients.	In progress	20%		70%		10%

• Standardize and better manage wound care supplies and reduce costs.	In progress	20%		60%		20%
• Funding models with effective incentives to prevent wounds and improve patients' quality of care and quality of life.	In progress	20%		50%		30%
Hospital led Clinical Effectiveness and Utilization committee identifies 2-3 priorities for clinical integration/consolidation; begin engagement and planning process.	In progress	50%		50%		
How will we measure success?						
The following indicators have been identified in the TC LHIN's 2013-2016 Integrated Health Services Plan (IHSP-3) to gauge the impact of these actions on patients and health system performance. The indicators will be revisited and potentially updated, and associated targets will be developed later in 2013 to align with and support Health Links, the Seniors Strategy and any other new elements of the Ministry's health care transformation plan : <u>Indicators</u> Hospitals consistently apply best practice clinical models. New community-based models of service delivery implemented to improve care for target populations Increased percentage of Toronto hospitals adhering to stroke best practice care pathways. Increased percentage of Toronto health service providers adhering to wound care best practice care pathways. Number of new models of integrated clinical service delivery introduced by health service providers. Number of target populations supported by new models of service delivery and integrations in the community sector.						
What are the risks/barriers to successful implementation?						
Stretched sectors and ability to drive change is unproven.						

Significant change management required to redesign major clinical services and community sector.
What are some of the key enablers that would allow us to achieve our goal?
• Strong health service providers leading projects “on the ground”. • HSP Board support and leadership for system solutions. • Effective patient, client, community input and engagement. • Physician and other clinical champions. • Reliable and current evidence-base and data to guide decision-making. • Something about TC LHIN’s information and business intelligence capacity to support system and local level system planning around specific populations and sub-LHIN areas. • Collaboration with other funders such as United Way, City of Toronto, etc.

Integrated Health Services Priority:
Sustaining our Gains
IHSP Priority Description:
The TC LHIN has made marked progress in reducing the amount of time people spend waiting in the ER and for key surgeries and diagnostic tests. And we have significantly improved ALC patients. Community support services and mental health and addictions services are better coordinated and accessible as a result of the creation of single access points and streamlined client assessments. The TC LHIN will continue to sustain these improvements while we move forward with the other priorities in our Plan.
Current Status:
Population and services • There were 378,079 ED visits by Toronto Central LHIN residents in 2010/11, and 16.8% of these visits occurred in other LHINs. Between 2006/07 and 2010/11, there was an increase in both ED visits and visit rates for Toronto Central LHIN residents. • • In 2010/11, The proportion of ED visits in Toronto Central LHIN hospitals for mental diseases and nervous system diseases was the largest in the province, while the proportion for respiratory system diseases was the smallest in the province. • The ED visit rate is the disproportionately higher for seniors aged 75+ in the TC LHIN. <u>Mental Health and Addictions:</u> • One out of every five people will experience a mental health issue in their lifetime. Demand for mental health illness and addictions services in the LHIN is on the rise. Population growth may account for part of this increase but other factors are likely contributing to more people seeking

help for mental illness and addictions. Mental health illness and addictions is one of the most costly health care issues and the main reason for ER visits and readmissions to hospital.

- The Toronto Central LHIN is within corridor on repeat visits for mental health conditions; however this is the highest rate of all Ontario LHINs.
 - The TC LHIN's MLPA Target for repeat visits for mental health conditions is 25%. At Q3, 2011/2, the LHIN was at 25.10% for this indicator. The mental health condition with the greatest percentage of repeat visits for TC LHIN is schizophrenia and psychotic disorders.

ALC:

The main contributors to ALC is supporting patients who have been in hospital for a long period (greater than 40 days) and helping patients to transition to and from rehabilitation and complex continuing care hospitals more smoothly and sooner. Among these clients are people with significant mental health and addictions and behavioural issues, people who are ventilator dependent and transitional aged adults with significant physical and cognitive disabilities.

Issues

ER

- The challenge remains getting patients in the ER treated and admitted to hospital beds in the timely manner as a result of ALC patients waiting to be discharged.

Innovations including short-stay units and transitional supports that treat patients for short periods instead of being admitted to hospital are helping to free up inpatient beds for people who need them.

ALC

- In September 2012, there were 296 "long-stay ALC" patients, an increase over September 2011.

There is a need for both specialized capacity to transition and support long-stay ALC clients to the right place of care and a collaborative health system plan to create the pathways and ability to identify and address people's needs earlier in their journey to prevent them from becoming long-stay ALC.

Long-term care home capacity is a pressing issue in Toronto.

- This is largely because of the TC LHIN is losing LTC beds as homes leave the sector or locate outside of Toronto due to the high costs of building and operating in the city. LTC homes are at 103.3% occupancy and the median time for a client to be placed in a long-term care home is higher than the provincial average (112 days vs. 89). TC LHIN has the third lowest long-term care bed to population ratio in the province. At the same time, LTC residents have increasingly more complex needs, requiring specialized services that many homes are currently not equipped to provide. 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.
- There are 20% of ALC patients in hospital waiting to be repatriated to their LHIN of residence. TC LHIN is working with TC LHIN hospitals and CCAC to support effective discharge planning and processes across LHINs to support these patients to receive appropriate care, close to where they live, after their hospital care is completed.

Mental health and addictions

Progress towards recovery and wellness for people with mental illness and addictions involves not only an integrated, coordinated system of services, but also addressing important factors outside of health care such as affordable housing, education and employment, income, and eliminating stigma and discrimination.

Through consultations over the past several years, providers and mental health and addictions clients have pointed to the following challenges:

- Multiple, uncoordinated access points and fragmentation;
- Insufficient capacity in local agencies to meet need;
- Poor quality data for proactive planning;
- Inconsistent focus on the needs of consumers and their families.

The TC LHIN brought agencies together to tackle some of these challenges. We have made gains. But this is a starting point. The TC LHIN has the highest rates of repeat visits to the ER within 30 days of discharge for mental health and substance abuse of any LHIN. This is a reflection of growing demand and long waits for certain services in Toronto including substance abuse services. That is why TC LHIN has been using its available funding to support people with the highest needs and highest ER use.

Surgical wait times

Patients are waiting longer for **hip and knee replacement surgery** in TC LHIN than they were three years ago. These waits are largely the result of patients (some from Toronto and others referred from other LHINs) choosing to wait for particular orthopedic surgeons in Toronto. In fact, when people waiting for preferred surgeons are not included in the count, the majority of patients are waiting within the recommended target.

Successes over the last year

- TC LHIN's performance in ER Length of Stay improved steadily since Q1 of 2008/09 through to Q1 2011/12, however; since that time, performance has plateaued and improvements have been smaller.
- From Q1 2008/09 to Q1 2012/13, 90th Percentile ER length of Stay has:
 - Decreased from 46.4 hours to 25.8 hours for admitted patients of all CTAS levels (I-V)
 - Decreased from 6.5 hours to 4.7 hours for Non-Admitted Minor Uncomplicated Patients
 - Decreased from 10.8 to 8.0 hours for Non-Admitted Complex Patients

In 2012, the TC LHIN achieved its ALC target for the first time. While the total proportion of long-stay ALC patients is growing, the TC LHIN has had some success in addressing this challenge.

West Park continues to implement the LTV Strategy for the TC LHIN which supports the ongoing care

and management of individuals with long-term ventilation needs in the TC LHIN. The strategy is aimed at improving patient transitions and flow and preventing avoidable admissions and LS ALC designations. In addition to the gains made to date, new capacity enhancements being brought on line in Q3 and Q4, 2012/13 including:

- Enhanced basket of services for community clients
- 2 new supportive housing units for LTV clients
- 6 new enhanced living units

Early in 2011 a cross sectoral task force was created to a comprehensive plan for the ongoing care of individuals with severe behavioural issues including dual diagnosis in the TC LHIN. The report was entitled *Smoothing the Path: Addressing Alternate Level of Care Issues for People with Severe Behaviour Issues including Dual Diagnosis* and outlined a number of recommendations.

Some important progress:

- Enhancement of two geriatric mental health outreach teams to increase the specialized supports provided to LTC homes for individuals aged 40-65 with complex and responsive behaviours.
- High-support housing to transition targeted ALC clients with mental health and addictions and/or behavioural issues out of CAMH and other acute and rehab/CCC hospitals across the TC LHIN into a more appropriate community setting. Forty patients have moved and additional units will be created.
- Enhancement of mental health supports in residential high-support settings for individuals with dual diagnosis and complex behaviours. TC LHIN to implement the newly developed model for 5 patients per year to be moved to community.
- A review of high-support housing in the TC LHIN to identify opportunities for increased flow and to develop processes to prioritize access to high-support housing.

In August 2012, the LHIN convened a time-limited LTC Working Group chaired by the University Health Network and the City of Toronto to inform the LHIN on actionable strategies to address immediate capacity gaps and system pressures, and improve complex transitions to LTC homes in the TC LHIN. We initiated an Expression of Interest in November 2012 to LTC homes to provide specialized services to complex populations in hospital waiting for LTC placement.

Mental Health and Addictions

Here are some key mental health and addictions initiatives that are making a difference:

New and Expanded Services to Close Gaps

Through the *TC LHIN MHA Gap Analysis Report 2009*, the *Service Capacity Overview Project (SCOP 2010)*, think tanks on Homeless and Seniors, and a community-based research report titled *Let Me Tell You How it Really Works*, we now have a clearer picture of mental health and addictions in the LHIN to guide investments.

We have used available funding to target services for those with severe mental illness and addictions issues who have fallen through the gaps, including:

- Investments in the city's first supportive housing units geared toward people with addictions. Early findings indicate that, on average, clients living in these new 272 units are using the ER 68% less than they were before.
- New services including intensive case management and system navigation; Crisis Response services; and peer outreach services are helping more clients get and remain connected to services.

Coordinated Access Points

- Within the TC LHIN there are coordinated access points for Mental Health and Addictions Supportive Housing (CASH), psycho-geriatric beds, Withdrawal Management Services, Case Management and Assertive Community Treatment Teams, and most recently, addictions services.
- The TC LHIN joined forces with agencies to provide a program called Access1. This program supports clients with mental health illness and addictions and their families and by giving them easy access to a variety of services through one phone number.
- Now, once clients place a call to Access1, a specially-trained person is waiting on the other end ready to help the client navigate the complex mental health system and provide short-term support if appropriate.
- To build on this work, a cross-LHIN multi-service access model has been developed starting with TC and Central LHINs that aims to streamline access to mental health and addictions services across the City of Toronto.

Common Assessments

Providers across the TC LHIN have implemented a common tool for assessing the needs of mental health clients in the community– the Ontario Common Assessment of Need (OCAN). This assessment supports clients to identify their needs and how they wish them to be addressed.

Surgical and diagnostic wait times

Over the last three years, the TC LHIN's performance on some key health system performance indicators has steadily improved, while performance for others has been less consistent.

MRI Wait times

Today in TC LHIN more people are being seen within the target wait times for MRI. In 2011/12 the TC LHIN performed better than its target for MRI wait times for the first time. This improvement is a result of efficiency measures taken by TC LHIN hospitals and the increased availability of MRI machines in surrounding LHINs. To sustain these improvements, we will focus on the appropriateness of MRI scans and reducing unnecessary tests.

Cancer Surgery

Over the last three years, TC LHIN hospitals were able to meet growing number of people being treated for cancer while reducing overall cancer surgery wait times to below the targets.

TEMPLATE A: PART 2: GOALS and ACTION PLANS							
Goal (s)							
We will focus on persistent access challenges including: - Reducing long-stay ALC. - Supporting people to transition effectively to and from rehabilitation and complex continuing care hospitals. - Strengthening the capacity for LTCHs so that complex long-stay ALC patients can transition to the right place of care. - Implementing specialized supports/services will help address immediate capacity gaps and system pressures, improve patient transitions to long term care homes in the TC LHIN and reduce the number of long stay ALC clients in the LHIN.							
Consistency with Government Priorities:							
This aligns most with the Health Action Plan priority Right Care, Right Time, Right Place.							
Action Plans/Interventions							
Action Plans		Please indicate the status of project (Not Yet Started, In Progress, Deferred, or Completed) and if applicable, the % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after three years and implemented equally each year, enter 25% in each column.					
		2013/14		2014/15		2015/16	
		Status	%	Status	%	Status	%
CCAC ALC Improvement Plan Proactively identify and rapidly respond to high needs seniors at home and in hospital. Work with all hospitals so that <i>Home First</i> is offered to all seniors who could go home rather than be automatically referred to long-term care. Stop the generation of long-stay ALC patients by embedding CCAC intensive		In progress	100 %				

Two geriatric mental health outreach teams will provide specialized supports to younger LTC home residents (aged 40-65) who have complex behaviours.	In progress	70%		30%		
Continuing efforts to coordinate access and close the gaps in mental health and addictions, focus on 1%-5% high needs populations including children and youth services, and Aboriginal agencies. - Partner with Central LHIN to implement Access1 – a single number and gateway for people to access mental health care across the two LHINs. - Continue implementation and refinement of coordinated access model for addictions services and increase call volumes	In progress	33%		33%		33%
	In progress	70%		30%		
- Invest new resources to fill gaps by enhancing a number of the mental health and addictions programs that have been put in place in the past few years. <i>Will be implemented and prioritized in the context of Health Links</i> - Coordinated model for Mobile Crisis Intervention Teams (MCITs) across the city - Implement new services for target mental health and addictions clients including: -narcotics treatment focused on Aboriginal people and women. -new high-support housing units and services to help people with substance abuse problems. -Implement social housing partnership for tenants in high risk buildings, resulting in increased housing management capacity, delivery of MHA and primary care.	In progress	33%		33%		33%
	In progress	80%		20%		
	In progress	80%		20%		
	In progress	50%		25%		25%

Number of target patients benefiting from telehomecare and telehealth services.
What are the risks/barriers to successful implementation?
• It is challenging to coordinate the high number of disparate HSPs who serve mental health and addictions clients. • Change management is significant for innovative models of care using telecommunications technology.
Enablers
• Strong health service providers leading projects. • Infrastructure support from OTN. • Support from the ministry and OTN for innovative models of care that make use of telecommunications technology to care for patients in their home.

LHIN OPERATIONS SPENDING PLAN

Operations Spending Plan (FORM 1C)	Toronto Central			241	
LHIN Operations (\$)	2011/12 Actuals	2012/13 Forecast	2013/14 Plan	2014/15 Outlook	2015/16 Outlook
Operating Funding (excluding initiatives)	5,559,385	5,535,121	5,535,121	5,535,121	5,535,121
Initiatives Funding (e.g. E-Health, A@H, ED, Wait Time, LHINC.)	2,688,088	2,907,130	3,890,434	3,890,434	3,890,434
Salaries and Wages	3,250,010	3,570,300	3,568,544	3,568,544	3,568,544
Employee Benefits					
HOOPP	334,084	258,513	254,022	254,022	254,022
Other Benefits	385,835	486,091	489,183	489,183	489,183
Total Employee Benefits	719,919	744,604	743,205	743,205	743,205
Transportation and Communication					
Staff Travel	14,504	15,024	16,300	16,300	16,300
Governance Travel	481	4,500	3,250	3,250	3,250
Communications	40,125	63,576	52,200	52,200	52,200
Others	29,271	2,000	1,000	1,000	1,000
Total Transportation and Communication	84,380	85,100	72,750	72,750	72,750
Services					
Accommodation	266,306	358,951	367,240	367,240	367,240
Community Engagement					
Advertising	30				
Banking	-				
Consulting Fees	70,203	32,866	40,000	40,000	40,000
Equipment Fees	4,140	10,885	16,285	16,285	16,285
Insurance	10,418	12,000	15,000	15,000	15,000
LSSO Shared Costs	539,499	342,000	342,000	342,000	342,000
LHIN Collaborative	26,971	47,500	47,500	47,500	47,500
Other Meeting Expenses	26,310	30,808	32,346	32,346	32,346
Board Chair's Per Diem Expenses	22,050	34,364	42,000	42,000	42,000
Other Board Members' Per Diem Expenses	25,825	84,682	102,000	102,000	102,000
Other Governance Costs	19,323	15,955	10,930	10,930	10,930
Printing and Translation	43,229	45,000	10,930	10,930	10,930
Staff Development	67,550	55,629	64,692	64,692	64,692
Amortization of Tangible Capital Assets					
Total Services	1,121,852	1,070,640	1,090,923	1,090,923	1,090,923
Supplies and Equipment					
IT Equipment	330,366	18,000	13,462	13,462	13,462
Office Supplies & Purchased Equipment	51,559	46,477	46,237	46,237	46,237
Other S & E				-	-
Total Supplies and Equipment	381,925	64,477	59,699	59,699	59,699
Capital Expenditures					
LHIN Operations: Total Planned Expense	5,558,086	5,535,121	5,535,121	5,535,121	5,535,121
Annual Funding Target	-	-	-	-	-
Operating Surplus (Shortfall)	1,299	0	0	0	0
Amortization of Tangible Capital Assets					
Initiatives Spending					
E-Health	600,000	423,200	423,200	423,200	423,200
Critical Care	75,000	75,000	75,000	75,000	75,000
Aboriginal Community Engagement	27,500	20,000	20,000	20,000	20,000
ED Lead	75,000	75,000	75,000	75,000	75,000
Primary Care	21,875	75,000	75,000	75,000	75,000
French Language Health Services	106,000	106,000	106,000	106,000	106,000
French Planning Entities	568,713	568,713	568,713	568,713	568,713
ER/ALC	100,000	100,000	100,000	100,000	100,000
Behaviour Support Ontario	57,000				
RM&R	387,000	510,000	508,979	510,000	510,000
Other Initiatives - LHINC	670,000	670,000	670,000	670,000	670,000
RCC (one-time of \$284,217)		284,217	1,267,521	1,129,301	1,129,301
Other Initiatives - Shared Services - IT		740,000	740,000		
LHIN Operations and Initiatives- Total Actual/Planned Expense	8,246,174	9,182,251	10,164,534	9,287,335	9,287,335
The increase in LHIN Operations Budget and accompanying FTE is mainly related to the transfer of Diabetes Regional Coordination Centre (RCC) Program funding to the TC LHIN					

LHIN STAFFING PLAN (FULL-TIME EQUIVALENTS)

LHIN Staffing Plan (FTE - FORM 1D)		Toronto Central			241
Position Title	2011/12 Actuals	2012/13 Forecast	2013/14 Plan (May 29, 2013)	2014/15 Outlook	2015/16 Outlook
LHIN Operations					
CEO	1	1	1	1	1
Senior Director	5	5	5	5	5
Executive Assistant	2	2	2	2	2
Administrative Assistant	4	4	4	4	4
Receptionist	1	1	1	1	1
Community Eng and Communications Consultant	1	1	1	1	1
Planner	1	1	-	-	-
Sr Perf/Cont/Alloc Consultant	3	3	5	5	5
Business Manager	1	1	1	1	1
Financial Coordinator	1	1	1	1	1
Financial Analyst	4	4	4	4	4
Program Dev Consultant	2	2	1	1	1
Sr Planner	1	1	2	2	2
Sr. Integration Consultant	4	4	1	1	1
Perf Measurement Analyst	3	3	2	2	2
Sr. Community Engagement Consultant	1	1	1	1	1
Communications Coordinator	3	3	2	2	2
Health Design Consultant	1	1	1	1	1
Accounting Manager	-	-	1	1	1
Consultant	2	2	3	3	3
Sr. Consultant	2	2	5	5	5
Coorporate Coordinator	-	-	1	1	1
French Language Services Coordinator	1	1	1	1	1
Analyst	1	1	3	3	3
Senior Lead	1	1	1	1	1
Project Manager	-	-	2	2	2
GRAND TOTAL	46	46	52	52	52

COMMUNICATIONS PLAN

Part 1 – General Communication Plan
Objectives: What is the purpose of the ABP?
Business Objectives Guided by Ontario's vision <i>To Make Ontario the Healthiest Place to Grow Up and Grow Old</i>, the ABP is a blueprint for how TC LHIN will improve the quality of life for its residents through a more integrated, coordinated health system that responds to peoples' diverse needs and provides a better experience as they move between services, particularly for the sickest 1 and 5% of patients. Particularly, the business objectives of the ABP align with TC LHIN's strategic priorities as outlined in IHSP3: 1. Address the needs of the 1% of highly complex patients with the greatest needs, requiring the most resources; 2. Prevent and delay serious illness and injury among those who are at greatest risk of declining health; 3. Improve the patient experience; 4. Deliver value and sustainability through efficient use of resources; 5. Sustain our Gains. Communications Objectives The Annual Business Plan (ABP) articulates the TC LHIN's operational plan for 2013-14 to achieve the goals of the <i>2013-16 Integrated Health Services Plan</i>. Communications objectives include: • Raising awareness of the ABP to HSPs, community and other stakeholders in the TC LHIN about how it will provide a better quality of life for the people who receive health care in Toronto. • Promote understanding of, support for and involvement in the implementation of the priorities in the ABP.
Context: Why do we do an ABP?
The ABP identifies the most important actions that need to be taken to improve the urban health care system and respond to the needs of the city's diverse and ever-changing population. It is built on the input from a broad range of stakeholders TC LHIN consulted over the last year including patients, caregivers and community groups including Aboriginal peoples and the Francophone community; health services providers, MPPs and their staff, health professionals and other partners including the City of Toronto and the United Way. TC LHIN developed the ABP to clearly articulate measurable goals for the coming year and to assist in the formulation of plans to achieve these goals. The ABP also helps TC LHIN ensure that its goals and objectives are aligned with the priorities set out in the IHSP-3 and brings about focus and clarity of what is to be achieved in the coming year. Finally, ABP builds on the directions of the Minister of Health and Long-Term Care's Action Plan for Health care and supports major provincial initiatives such as Health Links.

Target Audience:
<u>Primary:</u> • Health service providers • Health professionals • Local health system partners • City Council and Departments • MPPs <u>Secondary:</u> • General public, current patients, clients and families • Other interested stakeholders • Media
Strategic Approach: What type of announcement?
Targeted announcement for the ABP focused on providing the plan directly to primary audiences and making it visible and available to secondary audiences through posting the ABP on the TC LHIN's web site, featuring it in the "What's New" section of the web site and referencing it in targeted communiques including briefing notes to health service providers. The TC LHIN will undertake different communications strategies in support of the ABP priorities and actions based on the specific objectives and audiences/stakeholders. This ABP will position the LHIN as a valued key player within the transformation of Ontario's health system and as the lead in health system transformation in the Toronto Central region.
Key Messages:
The Toronto Central LHIN's 2013-14 Annual Business Plan lays out the steps we will take this year to improve the quality of care in the local health system and the experience of all patients receiving services in our region. People are telling us that they value the care they receive, but they want a better health care experience. They find the system difficult to navigate the system and they want more access to day-to-day health care including family physicians and home care. Health care costs will grow because the population is growing and aging. Our plan aims to help <i>reduce</i> the <u>rate</u> of growth while <i>increasing</i> value through better quality of care. We will emphasize improving health care for people with the greatest health needs who use the most resources. The TC LHIN has 5 priorities to transform the local health care system:

1. Address the needs of the 1 per cent of highly complex patients with the greatest needs who require the most resources.
2. Prevent and delay serious illness and injury among those who are greatest risk of declining health.
3. Improve the patient experience
4. Deliver value and sustainability through efficient use of resources.
5. Sustain our Gains

A year from now the local system will be more integrated and able to respond to the needs of the patients and communities we serve. People will have a better experience as they move between services and patients and caregivers will have more information and greater influence in their care.

Given the fiscal and demographic pressures, it is imperative that we transform Ontario's health care system so that it will meet the needs of current and future generations of Ontarians. The status quo is unsustainable. Growing and aging populations increased incidents of chronic conditions and the current fiscal reality have created an urgent need for change.

Everyone has a role to play in the change. We are working with the health care community and Ontarians in our LHIN to transform the way health care is delivered, funded and accessed based on evidence, value-for-money and innovation.

Tactics – High level, if available

Audience Stakeholder	Tactics
Corporate communications	
All audiences	Suite of new community-oriented communications vehicles inform stakeholders and community members including: updated TC LHIN infokit TC LHIN e-bulleting – Compass Blogs Report to the Community
All audiences	Enhanced use of social media to increase the reach and effectiveness of messaging and information and dialogue with stakeholders. – Facebook, Twitter, YouTube.

	Weekly and monthly social media calendar
MPPs and staff	MPP breakfast with TC LHIN Board and CEO Update on TC LHIN's IHSP-3 priorities and key transformation initiatives – local implementation of Health Links, building capacity of the community sector, clinical integration initiatives for stroke, hip and knee rehab and wound care. Lunch and learn with MPP staff (these are in addition to ongoing updates and engagement of MPPs and staff)
Address the needs of the one percent of highly complex patients with the greatest needs, requiring the most resources.	
Discharge Planning communications - HSPs - Primary Care - Other front-line health professionals - Ministry - Local patient groups and associations in TC LHIN - Relevant TC LHIN advisory groups including Health Professionals Advisory Committee, Reflet Salveo for the Francophone community and the interim Aboriginal Advisory circle - MPPs	Incorporate information about project milestones, benefits to patients and providers in TC LHIN communications vehicles – Compass e-news bulletin, social media Stakeholder communicate to announce “go live” of electronic discharge planning information. Targeted communications to primary care and Health Links partners - incorporate into fact sheets, backgrounders and communiques from Health Links and TC LHIN (e.g., regular joint TC LHIN – OMA District 11 newsletter), include in presentations

Integrated TC LHIN Palliative Care Strategy • HSPs • Health professionals • Ministry • Local patient groups and associations in TC LHIN • Seniors groups in TC LHIN, e.g., CARP local chapters • Relevant TC LHIN advisory groups • Ministry • MPPs • Media	TC LHIN Branding strategy - name and visual identify reflecting TC LHIN system initiative Presentations to reach HSPs and other palliative care stakeholders about the plan to integrate and improve access to palliative care across the continuum. Create Palliative Care Strategy information kit and repurpose key messages and materials for different purposes. Incorporate information about strategy milestones, benefits to patients, providers and the health system in TC LHIN communications vehicles – Compass e news bulletin, social media, web site, Report to Community, Annual Report Media and stakeholder announcement with strategy partners of the TC LHIN's plan and what will be different for clients and caregivers.
Audience Stakeholder	Tactics
Prevent and delay serious illness and injury among those who are at greatest risk of declining health – five percent of the population.	
Implement 9 Health Links to integrate and improve services at the local level. • HSPs • Primary Care physicians and practices – FHTs, CHCs etc. • Other primary care providers • Health Link members • Other health professionals • Patients and community members in the Links, beginning with the early adopters • Local patient groups and associations in TC LHIN	<i>Health Links in TC LHIN</i> information package including Health Links presentation and fact sheet, Implementation Plan and other backgrounders, FAQs Stakeholder presentations to reach HSPs and other stakeholders about the TC LHIN's Health Link strategy. Targeted communications to Health Links members regarding updates in Health Links strategy. Primary care engagement and communications strategy to support and complement local Health Link physician engagement including: • Physician engagement sessions co-hosted by TC LHIN, OMA District 11 other partners • Joint TC LHIN-OMA newsletter • Incorporate Health Links awareness primary care engagement activities led by TC LHIN's

• Relevant TC LHIN advisory groups • MPPs • City Council and key city departments • Media	3 primary care advisors Support and participate in local media announcements and media pitches in collaboration with Health Links.
Regional Diabetes Program • HSPs • Diabetes program partners including Diabetes Education Programs • Health professionals • Health Link members • Local patient and community groups including seniors, Aboriginal, Diabetes Association, Kidney Foundation. • Relevant TC LHIN advisory groups • MPPs • Media	Branding TC LHIN's regional diabetes program reflecting TC LHIN leadership and future plans to enhance diabetes prevention and management. Media and stakeholder announcement regarding the 2013-14 diabetes plan prevention and management for TC LHIN Development of physician and health professional engagement and outreach strategy Basic communications information kit. Incorporate information about program benefits to patients, community, and providers in TC LHIN communications vehicles Tailored communications to specific communities including Aboriginal people and Francophone community – direct and via community groups (e.g., Reflect Salve)
Improve the Patient Experience	
Measure, Report on and Improve the Patient Experience • HSPs • Health professionals • Health Link members • Ministry • Local patient and community groups. • Relevant TC LHIN advisory groups including Health Professionals Advisory Committee, Reflect Salve for the Francophone community and the interim Aboriginal Advisory circle	Launch initiative with stakeholders, HSPs and patients and community members via local patient and consumer intermediary groups e.g., Patient Destiny, CARP local chapters, Reflect Salve, mental health and addictions client and family advisors. Basic communications information kit. Inform and engage stakeholders about the initiative through meetings and presentations. Incorporate information about initiative and benefits to patients and providers in TC LHIN communications vehicles. Matt story and/or blog for stakeholder and patient/client group newsletters and web sites.

• MPPs	
Audience Stakeholder	Tactics
Health Access St James Town • HSPs • Health professionals • Health Link members • Ministry • Local patient and community groups. • Relevant TC LHIN advisory groups • MPPs • City Council and key city departments	Announce new services initiatives and results, community input through HASJT web site. Regular project bulletins to the community (in multiple languages) – co-branded with TC LHIN and partners (United Way, St. Michael's, Toronto Community Housing) HASJT blog for local community members and stakeholders Presentation involving St. James Town community members to the Board. Inform and engage stakeholders about the initiative through meetings and presentations. Incorporate information about initiative and benefits to patients and providers in TC LHIN communications vehicles.
Improving care for Francophone • HSPs • Health professionals • Health Link members • Ministry • Reflect Salve • Francophone community members and groups, include immigrant and refugee groups • Relevant TC LHIN advisory groups • MPPs • City Council and key city departments	Stakeholder announcement and broad distribution of TC LHIN FLS population and service map to Health Links (for TC, MH and CW LHINs), HSPs and other stakeholders. Collaborative release of Reflect Salve's advisory reports.
Improving Care for Aboriginal People • HSPs	Presentations/speaking opportunities at Aboriginal community, health care and City of Toronto events/conferences.

• Aboriginal agencies, peoples, groups • Ministry • Media – mainstream and Aboriginal • Health Link members • Local patient and community groups. • TC LHIN advisory groups • MPPs City Council, departments	Targeted communications about milestones and results of MHA and youth projects to Aboriginal community and media and mental health and addictions agencies and groups – Incorporate information about TC LHIN's Aboriginal programs and investments in TC LHIN communications vehicles.
Audience/Stakeholder	Tactics
Deliver value and sustainability through efficient use of resources.	
Resource Matching and Referral • HSPs • Health professionals using the system • Other LHINs • Ministry • ehealth stakeholders • Relevant TC LHIN advisory groups • MPPs	HSP and stakeholder focused communications plan and activities to support implementation of RM&R locally and provincially (in collaboration with implementation lead St. Joseph's Hospital and other LHINs) including: • Regular project newsletter for Provincial Alternate Level of Care RM&R Business Transformation Initiative
<u>TC LHIN Community Transportation initiative</u> • HSPs • Health professionals • Health Link members • Ministry • Local patient and community groups, including seniors. • Relevant TC LHIN advisory groups • MPPs • City Council and key city departments • United Way	Presentations to reach HSPs and other stakeholders about the plan to strengthen and sustain community-based transportation services Create information kit. Incorporate information about strategy milestones, benefits to patients, providers and the health system in TC LHIN communications vehicles. Targeted media relations focus on community, ethnocultural, seniors media
Expanding community-based health care for high-	Stakeholder presentations to reach HSPs and other stakeholders about the plan to strengthen and enhance sustainability of community-based

needs clients (1% and 5%) Investments in enhanced adult day programs and Assisted Living Services • HSPs • Health professionals • Ministry • Health Link members • Local patient and community groups, including seniors. • Relevant TC LHIN advisory groups • MPPs • City Council and key city departments • United Way	transportation. Create information kit. Incorporate information about strategy milestones, benefits to patients, providers and the health system in TC LHIN communications vehicles. Targeted media relations focus on community, ethnocultural, seniors' media. Media announcement about new investments – mainstream and community, ethnocultural, seniors and other client groups' media.
Community Information Infrastructure Program (CMHA & CSS) • HSPs – focus on community HSPs – CSS, CMHA, CHC, CCAC • Ministry • Health Link members • Local patient and community groups, • MPPs • United Way	Targeted communications to community sector to support adoption and change management for central IT and business intelligence systems for the community sectors – including communiques, presentations at TC LHIN community sector tables and other forums. Highlight in TC LHIN communications vehicles including Compass e-news bulletin, Report to the Community, Annual Report, Health Link communiques and include in HSP newsletters and other vehicles
LTC sector redesign • HSPs • Health Link members • Local patient and community groups, focus on seniors • MPPs • City Council and relevant departments • United Way	Targeted communiques to LTC sector, other HSPs, City departments, seniors and LTC home residents and family councils. Highlight in TC LHIN communications vehicles.
Integrated Stroke Care, hip and knee rehab and wound care models • HSPs • Health professionals, focus on relevant	Branding reflecting TC LHIN system initiatives and HSP partnerships. Basic information kits for each initiative. Media and stakeholder announcements of new models and what it means for patients, seniors,

- specialists - Health Link members - Ministry - Local patient and community groups, including seniors. - Relevant TC LHIN advisory groups - MPPs	providers and the system. Targeted messaging and information about each clinical integration project targeting different health professionals, clinicians and patients. Incorporate information about strategy milestones, benefits to patients, providers and the health system in TC LHIN communications vehicles. Matt stories and blogs for HSP and stakeholder vehicles and sites. Presentations/ speaking opportunities to reach HSPs and other stakeholders.
Audience/Stakeholder	Tactic
Sustain our Gains	
Supporting vent dependent patient who are long-stay ALC transition to right place of care - HSPs - Targeted health professionals - Ministry - Disability groups - Relevant TC LHIN advisory groups - MPPs	Targeted communiques to interested stakeholders Key messages - general and targeted Incorporate information about strategy in TC LHIN communications vehicles.
Implement initiatives to create capacity in long-term care homes - HSPs - Health professionals - Seniors groups, resident and family councils, patient/client groups for Alzheimer's/dementia and other conditions - Health Link Members - Relevant TC LHIN advisory groups - Ministry - MPPs	Key messages – general and targeted Incorporate information about the strategy milestones, benefits to residents, families, providers and health system in TC LHIN communications vehicles. Inform and engage stakeholders about the initiative through meetings and presentations

• City Council and relevant departments	
CCAC ALC initiatives • HSPs • Health professionals • Seniors groups, resident and family councils, patient/client groups for Alzheimer's/dementia and other conditions • Health Link Members • Relevant TC LHIN advisory groups • Ministry • MPPs	Coordinate communications messaging and tactics, including media stories. with TC CCAC, Incorporate information about the strategy milestones, benefits to residents, families, providers and health system in TC LHIN communications vehicles. Inform and engage stakeholders about the initiative through meetings and presentations.
Mental Health and Addictions – new initiatives for high needs client High-support housing for high-needs individuals with dual diagnosis and behavioural issue Geriatric mental health outreach teams will provide specialized supports to younger LTC home residents • HSPs • Health professionals • MHA clients and families and groups representing them • Health Link Members • Relevant TC LHIN advisory groups • Ministry • MPPs • City Council and relevant city departments	Key messages for each initiative – general and targeted Incorporate information about the strategy milestones, benefits to clients, families, providers and health system in TC LHIN communications vehicles. Inform and engage stakeholders about the initiative through meetings and presentations.
New and expanded services to close care gaps for MHA clients.	

• HSPs • Health professionals • MHA clients and families and groups representing them • Health Link Members • Relevant TC LHIN advisory groups • Ministry • MPPs • City Council and relevant city departments • Media • Other partners – e.g., Toronto Police <u>Coordinated model for Mobile Crisis Intervention Teams (MCITs) across the city</u> <u>Narcotics treatment focused on Aboriginal people and women.</u> <u>Integrated Withdrawal Management Services Model</u>	Information kits for each initiative Media and stakeholder announcements for these new services, in partnership with HSPs and other partners, e.g., MCIT with Toronto East General Hospital, other hospitals, MHA agencies, Toronto Police Services, clients and community members. Incorporate information about the strategy milestones, benefits to clients, families, providers and health system in TC LHIN communications vehicles. Inform and engage stakeholders about the initiative through meetings and presentations. Matt stories and blogs for HSP and other stakeholder publications and sites.
Evaluation	
Media monitoring – monthly and annual report Web site and social media analytics – monthly and annual report Stakeholder event evaluations and surveys Patient and public complaints, compliments and queries tracking – annual report	

7.4. Template E: Community Engagement

Community Engagement
Provide a description and plans for community engagement including a description and plans for specific initiatives for which the LHIN receives additional operational funding (e.g. e-health, aboriginal health planning) The TC LHIN will use a mix of community engagement techniques tailored according to

the objective, community and stakeholder's needs and other strategic considerations.

Community/Stakeholder	Initiatives
Health Service Providers	
	Standing TC LHIN advisory committees • Health Providers Leadership Forum (cross-sector, bi-annual forum) • Sector Tables (quarterly and as needed) • Health Link Strategic Advisory Council (to be created in 2013) • Quality Table Each TC LHIN initiative has a time-limited, specific advisory or working group with membership from HSPs, other stakeholders, patients, community members. TC LHIN sometimes co-chairs and participates. Some committees report to the LHIN. TC LHIN uses other engagement tactics including presentations meetings, surveys, thinks tanks, focus groups to engage HSPs. TC LHIN Board-to-HSP Board engagement • Board-to-Board sessions to inform/involve HSP Boards in transformation initiatives including Health Links, e.g., community sector capacity building; clinical service integrations. • Issue specific TC LHIN Chair or Board meetings with HSP Boards. • Tailored information and updates for HSP Boards.
Health Professionals	
	Standing TC LHIN advisory groups • Health Professionals Advisory Group Health professional membership in key LHIN standing and initiative-specific advisory and working groups including Quality Table. Partner with health professional groups and associations to engage members e.g., OMA District 11. Primary care engagement TC LHIN engages primary care providers directly in support of Health Links planning and implementation

	through: • Outreach led by the TC LHIN's three Primary Care Physician Advisors – specific activities for organized group practices, solo practitioners and CHCs. • Partnership with OMA District 11 to deliver engagement sessions on key topics and a joint TC LHIN – OMA District 11 primary care newsletter.
Public, patients, clients, caregivers	
General public, patient clients and caregivers	The TC LHIN has a number of general engagement mechanisms to support engagement: • Partnering with providers, patient and community groups to develop and implement engagement strategies. • Using social media, media, conferences and events, focus groups, deliberative discussion groups, surveys. • Public and patient presentations at TC LHIN Board meetings and delegations to Board. • Including patient/client, family, caregiver representatives on advisory groups and think tanks • Staff and Board community tours Community engagement requirements are included in all TC LHIN funded projects and integrations and changes requiring TC LHIN oversight including capital projects. A TC LHIN-HSP reference group of community engagement professionals collaborates to develop engagement tools and share strategies and best practices.
Diverse communities/people with barriers to participation	While established community engagement approaches have their place, they can present a skewed perspective. Their design unintentionally excludes many: those with physical or cognitive disabilities, an inability to speak English or French, poverty, isolation and marginalization. Many of the excluded have high needs and are frequent users of the ER and other costly services. The TC LHIN's focus is on developing different approaches to include voices that have been largely absent. The following are some current TC LHIN initiatives:

	Health Access St. James Town The TC LHIN is leading an initiative in partnership with United Way, Toronto Community Housing, the City of Toronto and St. Michael's to improve access to services for the populations in St. James Town. Patients and local residents are involved at every step of the Health Access St. James Town initiative. The focus is on the entire continuum of services, with an emphasis on primary care and transitions within health care and between health and social care. This initiative is not only designed to make concrete changes to health care delivery for the community's underserved and high-needs populations, it is testing strategies for engaging community members and patients in local health service design. Information and tools from this project can be adapted by Health Links for local activities. The project uses community animators who are members of different ethnocultural, linguistic and other communities living in the neighbourhood. These animators are trained to survey and interview members of their community in their first language. They also help facilitate community meetings including providing real-time "whisper translation" so that people could participate in multiple languages. This project can provide information about how to design and deliver different kinds of community meetings with diverse communities. The TC LHIN is supporting a Health Access St. James Town web site which includes a news bulletin, a blog, discussion groups and survey tools to enable dialogue among community members and area providers. Engaging Mount Dennis The TC LHIN has partnered with Patient Destiny, a Toronto patient-led group to engage the residents of Mount Dennis a priority neighbourhood in west Toronto. The goal is to hear first-hand about the population's health needs and roadblocks in accessing services in their community to help identify strategies for improvement. The project will use customized community engagement approaches developed in partnership with community members and will focus on specific ethnocultural groups including the Somali community; high needs, complex seniors; children/youth; and single-parent families. The project will produce a report that will inform local
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	health care planning. It will also create and test a model for enabling the participation of diverse populations in local health service planning.
Francophones	Standing processes for including Francophone community voices in TC LHIN planning and decisions: • Partnering with the TC LHIN's French Language Services (FLS) Health Planning Entity, Reflet Salveo to engage local community groups and Francophone agencies. • TC LHIN FLS Core Group of HSP representatives responsible for FLS to advance best practices and collaborative plans to increase the active offer of FLS to Francophone patients/clients. TC LHIN ensures that Francophone engagement is included in TC LHIN priority initiatives and uses translation and interpretation to support Francophone participation. • TC LHIN has a particular focus on reaching the high and growing number of Francophone immigrants and refugees who face multiple equity issues by building relationships with community leaders and agencies serving them such as Ontario Council of Agencies Serving Immigrants, African Canadian Social Development Council
Aboriginal people	There are a few ongoing forums to engage Aboriginal communities in the TC LHIN: • Interim Aboriginal Advisory Circle of Toronto Aboriginal health and other Aboriginal community agencies involved in health care delivery. • Participation along with Toronto Public Health in an Urban Aboriginal Roundtable for the City of Toronto with broad membership for Aboriginal agencies. TC LHIN is a member of the Provincial LHIN Aboriginal Network which engages provincial Aboriginal, First Nations and Metis stakeholders on provincial issues and strategies. Ongoing engagement processes include participation in Aboriginal Forums and traditional events. TC LHIN partners with Aboriginal agencies to

	undertake Aboriginal community-led engagement processes. For example Anishnawbe Health Toronto led engagement with Aboriginal Youth experiencing mental illness and addictions to inform the design of new services for young Aboriginal people with mental health and addictions issues. TC LHIN is with the Centre for Research on Inner City Health (CRICH) and community engagement and development experts from provider organizations to develop collaborative engagement process for specific communities. The aim is to design engagement processes that are rigorous, culturally competent and to have providers work together to engage shared communities of interest to improve the process and outcome. The first target communities are Lesbian Gay Bisexual and Transgendered people and Aboriginal people.
MPPs	
	TC LHIN engages MPPs and their staff ongoing through direct contact and problem-solving for specific issues, regular targeted communiques including briefing notes, fact sheets, key messages, and corporate communications vehicles – social media, news media, e-news bulletin, publications. TC LHIN has one-on-one meetings with MPPs and staff regarding specific local issues and initiatives. We collaborate with MPPs’ offices on local community engagement activities. We hold annual or bi-annual meetings between all MPPs, the TC LHIN Board and CEO regarding key health system transformation initiatives. TC LHIN has an annual “lunch and learn “with MPPs’ constituency staff to inform staff about the TC LHIN and key initiatives and impact on local health services and constituents.
City of Toronto	
	The TC LHIN and GTA LHINs and City are creating a joint leadership table to identify and advance mutual strategies to improve the health and well-being of Torontonians • 5 GTA LHIN-City Leadership Table will include five TC LHIN CEOs and executives representing key city departments impacting population and

	community health. TC LHIN engages specific City Councillors on key issues that are of interest in their wards or to their committee roles. TC LHIN works with specific City Departments on relevant initiatives, particularly related to services for high-needs populations: Toronto Public Health, EMS, City Planner; Long-Term Care Homes and Services; Shelter Support and Housing, Toronto Community Housing, TTC; City's Seniors Strategy Expert Panel
Other partners	
	TC LHIN engages strategic partners to advance initiatives to improve the health and wellbeing of the local population and other strategic aims: United Way of Toronto; provincial agencies including eHealth Ontario, Health Quality Ontario, Cancer Care Ontario and Ontario Telehealth Network; research and data partners – Toronto Community Health Profiles Partnership, Institute for Clinical Evaluative Sciences.
ehealth stakeholders	
	There are various tables and processes for engaging ehealth stakeholders to steer, guide and support implementation of TC LHIN, GTA and provincial ehealth initiatives including: Connecting GTA Steering Committee Resource Matching and Referral Steering Committee GTA Health Information Collaborative (HIC) GTA West DI-r Project - Exec Meeting

LSSO AND LHINC SUBMISSIONS

LSSO 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, all of which make an equal contribution to the LSSO annual funding. LSSO provides essential back office services such as information technology, procurement and vendor management, finance, accounting, payroll, legal, and HR advisory services to all the LHINs. LSSO is a division of the TC LHIN, and its Senior Director reports directly to the TC LHIN CEO, who is accountable to the TC LHIN Board.

LSSO mandate to provide services to the 14 LHINS is detailed below:

1. Application & Technology management and support services for:
 - a) GP Dynamics Financial and Human Resource Information System
 - b) SharePoint and CRM Solutions
 - c) Website hosting and development
 - d) Overall IT network and service support
2. Payroll and Benefits processing services
3. Procurement and Vendor management and advisory services
4. Project Management and HR Advisory Services
5. Funding for Legal Services Branch

Based on KPMG recommendations stemming from its 2011 review, the LSSO provides pivotal core support in nine delivery areas. Information Technology, Procurement, Human Resources, Decision Support, and Finance are identified as priority services for the 14 LHINS, whereas Communications, Policy Development, Planning and Project Management are secondary services.

Recommendations for the Information Technology, Procurement, Human Resources and Finance service areas were approved by the 14 CEOs to proceed. This business plan has been prepared taking the Task Force recommendations into the account.

Current Status

Departmental Operations- LSSO Operations

LSSO is accountable for the delivery of two distinct service functions: core services are services in which all LHINs must participate; and optional collaborative services represent additional service functions that are shared across all LHINs, wherein LHIN participation is encouraged but not obligatory.

LSSO continues to collaborate with the LHINs to review current approaches and develop strategies for optimized back office service delivery and support. Feedback and recommendations come from both discussions with the LHINs and the Task Force. Key functions and initiatives have been identified and included in this report, and both budget requirements and the estimated budget pressures have also been identified.

LSSO Operations- Planning and Outcomes

LSSO's commitment to efficient, high-level shared service delivery is maintained through the Shared Services Implementation Committee (SSIC), which continues to implement recommendations from the Task Force in its planning. Policy development and project management committees provide guidance and continue to prioritize common initiatives, policies and project management approaches. An enhanced communications plan allows for improved and timely transmission of LHIN priorities and planning.

LSSO operations also include finalizing additional budgets for internal resources, staffing, and support for core and optional service delivery, as well as the delivery of additional priority and secondary services as identified by the Task Force. Staffing support is important to ensure that LSSO staff have the skills required to meet objectives and continue to implement the service delivery model recommended by the Task Force. As well, IT project delivery and service improvements have resulted from enhanced project planning and coordination.

Departmental Operations- Information Technology services

IT services are core function of LSSO and it is accountable for the services provided to the 14 LHINs through outsourcing. This services includes:

- ensure the sustainability of technology solutions and to mitigate the financial risk associated with non-standard technologies
- improve the availability and access of information
- ensure that IT is not restricting the LHINs ability to adapt and adopt to changes in the IT industry rapidly
- improve the overall delivery of IT Services and Solutions

Departmental Operations- Procurement Office

Procurement services are a core function of LSSO, and it is accountable for the services provided to the 14 LHINs through outsourcing. This process can be grouped into three diverse components:

- Providing professional advice and expertise throughout the Procurement Process, including strategic sourcing and managing compliance obligations
- Managing and communicating Vendor Records to LHINs, including updating templates, tools, and process and tendering documentation and reports
- Researching and preparing RFPs, managing and tendering of solicitation documents developing contracts and managing contract negotiations

The Strategic Action Plan has provided a framework to proceed with an RFP which will successfully establish a continuity of Procurement services to all 14 LHINS. Outsourcing will allow increased focus and commitment to each of the distinct Purchasing components, including an enhancement of VOR information management.

Clarification of roles and responsibilities will develop with a focus on RFPs, such as what occurred with the IT RFP process. Outsourcing will allow for increased managing and monitoring of Purchasing professionals as they undertake negotiations and activities on behalf of LHINS, and improved communication on deliverables.

Departmental Operations- Human Resources

HR services are a core functionality provided by the LSSO. Ongoing monitoring of key internal HR services and their policies allows for refinement and further development to deliver effective results. These services include: compensation management support; performance management guidelines; employee wellness (e.g. EAP, Occupational Health and Safety); training and development; on-boarding materials; labour/employee relations; and expert payroll, benefits and pension administration.

Successful HR initiatives and improvements of the past year have included:

- Establishing the new human resources information system (HRIS) system with portals for the LHINS, creating one central point for HR information access
- Obtaining an effective payroll outsourcing solution to provide an important centralized system for use by all 14 LHINS
- Implementing a productive payroll portal for employees, allowing for faster, more efficient access to information
- Developing and implementing new employee on-boarding templates
- Receiving LHIN CEO agreement and acceptance of performance templates

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 (server, email, database)

- Network
- Telecommunications
- Business continuity plan
- Security and access management
- Inventory/asset management

In consultation with the TC LHIN stakeholders the LSSO has identified the following action plan have been identified:

1. Ensure new IT vendor to provide on-site support for local and remote offices as part of the contract services with a plan to prepare and issue an IT RFP and the selected vendor will provide custom application development and maintenance support, and LSSO to manage the contract. LSSO will also develop a change strategy and execution of exit from the current vendor contracts for IT infrastructure services
2. Implement a document management system such as Microsoft SharePoint to make business collaboration a platform to work together, empower people, help cut costs with a unified infrastructure and store information
3. Develop a service category to provide clear definition of available services. Ensure this service category is communicated to all LHINs while clarifying the roles and responsibilities of LSSO and communicate this info to LHINs via intranet. This is expected to improve quality of service delivery through continuous project planning and coordination. It will maintain open communication channels between LHINs and LSSO. All of these will be measured by performance indicators such as user satisfaction and response time.
4. 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
5. IT Solution LHIN user and facilities requirements in support of Diabetes program with a coordinated approach to managing the various LHIN user and supporting facility growth requirements.

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.

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 TC LHIN stakeholders the LSSO has successfully implemented the new finance and accounting system in all LHINs (GP Dynamics) within specified timeframe and signed off. Through an ongoing contract with the outsourced company, LHINs controllers have access to support as needed in their use of the system.

Payroll services

Payroll and benefits services are core services provided to all LHINs. A new payroll service solution had been launched in 2012-13 and the project is complete.

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 TC LHIN stakeholders the LSSO has identified the following action plan:

- Establish the project committee
- 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

SharePoint Initiative

The SharePoint initiative is a web-based intranet platform that is developed by the LSSO using the SharePoint platform to improve operational efficiencies through information collaboration and robust document management for individual LHIN and across the system

This project has two phases. Phase I has been implemented the SharePoint portal at 14 LHINs. Phase II began in fiscal 2012-13 and is expected to complete in 2013-14 upon availability of funds.

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 collaboration management strategies
- Integrate existing HSP SharePoint sites so LHINs can collaborate with HSPs through extranet
- Data migration
- Training and support

SharePoint 2013 is also under planning and will be discussed in second and third quarter of 2013-14 and its deployment subsequently.

CRM solutions initiative

Through the outsource partner, operational support in conjunction with an external implementation vendor, LSSO is supporting the deployment of CRM in 4 LHINs. CRM offers a variety of workflow improvement tools for contact management, contract management and engagement activities. It can be integrated with GP dynamics for account management and with SharePoint for business intelligence solutions.

Risk Assessment

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

- Balanced budget with increase in service requirements and initiatives (e.g. procurement office, project management, decision support & planning) with the impact of longer turn-around time, increased risk of deals that may not be cost-effective and LSSO jettisoning some areas of current responsibility. The mitigation may be in the form of reduction in spectrum of work and deferral of project until funding is secured
- Failure of LHINs to grant additional staffing request due to increase in support requirements/projects with the same impact described above and the current staff may not have the right skills to implement the service delivery model recommended by the Task Force. The mitigation is the same as above.
- Various project implementations will depend on internal subject matter experts (e.g. SharePoint, CRM, etc) and projects may be delayed if subject matter experts are not available due to other commitments, on vacation, leave of absence or timeline deferral. The mitigation is that third party experts are available if and when required
- Adequate and available LHIN staffing resources is a risk and the impact is that staff are heavily involved in daily operational efforts and is challenging to staff for additional commitments on initiatives and project completion is delayed. The

mitigation is to 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 (\$)	2010/11 Actuals	2011/12 Actuals	2012/2013 Forecast	2013/2014 Planned Expenses	2014/15 Planned Expenses	2015/16 Planned Expenses
Salaries and Wages	1,556,568	1,727,135	1,638,464	1,957,241	1,957,241	1,957,241
Employee Benefits						
HOOPP	70,892	129,720.26				
Other Benefits	151,174	81,235.74				
Total Employee Benefits	222,066	210,956	227,970	264,021	264,021	264,021
Transportation and Communication						
Staff Travel	15,924		21,154	25,154	25,154	25,154
Communications	15,837	25,196	11,969	32,000	32,000	32,000
Other Benefits						
Total Transportation and Communication	31,761	25,196	33,123	57,154	57,154	57,154
Services						
Accommodation	180,772	160,499	270,399	172,040	172,040	172,040
Consulting Fees	15,705	194,544	25,085	30,000	30,000	30,000
LSSO IT Contracted Services*	2,377,774	1,901,260	2,115,632	2,901,644	2,451,644	2,451,644
Other Meeting Expenses			5,260			
Staff Development		16,853	23,430			
Total Services	2,574,251	2,273,156	2,439,806	3,103,684	2,653,684	2,653,684
Supplies and Equipment						
IT Equipment and Software	508,995	944,843	1,014,214	645,307	645,307	645,307
Office Supplies & Purchased Equipment	89,942	62,272	87,981	67,539	67,539	67,539
Total Supplies and Equipment	598,937	1,007,115	1,102,195	712,846	712,846	712,846
Projects in Support of LHINS - TBD	199,347	165,327	100,000	237,976	237,976	237,976
LSSO Operations: Total Planned Expense	5,182,930	5,408,885	5,541,558	6,332,922	5,882,922	5,882,922
Annual Funding Target - To be funded by the LHINS						
Variance						

* Increase LSSO IT contracted Services for \$450k due to IT Disaster plan as recommended by the Ministry's auditor

Staffing Plan

Position Title	2011/12 Actual FTEs as of January 2012	2012/13 Forecast FTEs	2013/14 Forecast FTEs	2014/15 Forecast FTEs	2015/16 Forecast FTEs
Senior Director	1	1	1	1	1
Administrative Assistant LSSO/LHINC	1	1	1	1	1
Controller	1	1	1	1	1
Senior HR Manager	1	1	1	1	1
LHIN Leadership Council Executive Coordinator	1	1	1	1	1
Procurement Specialist	1	1	1	1	1
Procurement Administrator Assistant	-	1	0	0	0
IT/PMO Manager	1	1	1	1	1
LSSO IT Support	1	1	1	1	1
LSSO IT Support Coordinator	1	1	0	0	0
Project Manager	-	1	1	1	1
Project Coordinator	-	1	0	0	0
SharePoint Administrator/Developer	1	1	1	1	1
Administrator Assistant - Legal	1	1	1	1	1
Payroll Specialist	1	1	1	1	1
Financial Analyst	1	1	1	1	1
Total FTEs	13	16	13	13	13

2013-14 Budget assumptions

The following assumptions were considered when compiling the budget:

- All vacant positions are budgeted at mid-range of the pay scale group for the corresponding positions.
- Staff benefit costs are budgeted based on salaries for all positions.
- The costs for the TC LHIN Legal Services Branch are included in the budget.
- The cost of living adjustment and the performance increase are both at 0% and has been factored in the forecasts
- The rent cost is based on the cost of the lease agreement together with additional budgeted rental space.
- The one-time costs of the initiatives are identified as a separate line item and LSSO is expecting to obtain funding for \$0.7M for IT transition to a new vendor.
- With the Diabetes Regional Coordination Centre (RCC) Programs, it is expected to receive revenue of about \$0.15M to cover salaries and other costs.

Budget commentary

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

- The LSSO budget for 2013-14 is prepared on the basis of a balanced budget
- The LSSO budget for 2013-14 was based on current operating costs, adjusted to reflect one-time additional funding for IT transition costs.
- Any staffing required for future projects or initiatives not included in this document would be funded through project funding from the TC LHINs as those projects are requested and approved.

Funding Pressures

- LSSO will require funding for its new projects.

Future opportunities from IT strategy

- Provincial ESB and Domain repositories may provide a leverage point for collecting anonymous information from health service providers
- Support Business Intelligence and 2012 TCLHIN Information Management Strategy
- Provide mechanism for standardized data definitions across all LHINs
- Accommodate future information needs resulting from growth
- Move to open standards and Consumer IT
- Cloud Services
- Bring your own device (BYOD)
- Opportunity to improve and increase the scope of Business intelligence tools
- Focus on strategy and less on operations
- Opportunity to move to an evergreen strategy for devices and equipment

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

Projects and Initiatives	Fiscal 2013-14			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
IT managed services transformation				
Contract management				
Define IT requirements for Diabetes program				
Project Management including server management, storage utility, service desk				
Change management, incident management, problem management				
Development of service level agreements				
Service reporting				
SharePoint				
CRM				
Collaboration and Security implementation				

LHIN Collaborative (LHINC)

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. LHINC's responsibilities were expanded in 2012 to provide secretariat services to the LHIN leadership, enabling them to more effectively respond to ministry requests at a provincial level and ensuring timely response on emerging issues.

LHINC plays an essential role by supporting provincial dialogue on key strategies, enabling joint work, sharing leading practices, and coordinating across LHINs on information requests and emerging issues. This includes:

- **Enabling LHIN leadership to provide timely response on system change and strategic opportunities** – ongoing project support for Leadership Council and CEO work groups on a range of topics to inform system planning and dialogue with the ministry on transformation including development of briefings, surveys, white papers or reports as needed
- **Providing centralized project support for priority pan-LHIN initiatives** – provide project support for pan-LHIN projects to achieve ministry priorities such as Falls Prevention and the Palliative Care strategy, including project management support for provincial initiatives, engagement activities for implementation
- **Establishing tools and resources to share knowledge and improve communication** – improving knowledge management and collaboration across LHINs to support more effective use of resources, avoid duplication and facilitate adoption of leading practices
- **Provincial Service Accountability Agreements (SAAs) and Indicators** – acting as a central resource to coordinate all provincial activities in the development, consultations, engagement and education related to the annual L-SAA, M-SAA, and H-SAA process
- **Facilitating dialogue between LHINs and other health system leaders** – supporting ongoing dialogue between LHINs and other provincial system leaderships, including the establishment of the System Strategy Council, a provincial forum that brings together the LHINs with the major sector associations to discuss opportunities to advance the provincial agenda

2013/14 Business Plan

In accordance with its mandate, LHINC's ABP is based on priorities that are identified by the Ministry and the 14 LHINs through the LHIN Leadership Council (composed of LHIN CEOs and Board Chairs) and the LHIN CEO Council (composed of the 14 LHIN CEOs).

In 2013/14 LHINC will continue to grow and evolve as the LHINs mobilize to support implementation of the Minister's *Action Plan for Health Care*. Key areas of focus for 2013/14 include:

Enabling timely response on system change and strategic opportunities

- Providing ongoing secretariat support to the LHIN CEOs and Leadership Council to enable timely response on emerging issues and requests from the ministry
- Supporting joint work on key provincial priorities including Health Links, quality, and the implementation of the Seniors Care Strategy
- Enhancing reporting at the provincial level on pan-LHIN activities, as well as progress on key provincial priorities and pan-LHIN imperatives
- Routinely undertaking surveys and analysis across LHINs to create a provincial snapshot of LHIN activities and leading practices

Centralized project support for priority PAN-LHIN initiatives

- Providing project support, progress reporting and communication of results and successes on several provincial priorities including falls prevention, the palliative care strategy, CCAC performance, seniors friendly hospitals and transition management

Tools and resources to share knowledge and improve communication

- Improving support to the ministry and LHINs on communications and issues management, with an expanded role providing communications support on pan-LHIN, provincial issues
- Routinely undertaking surveys and analysis across LHINs to create a provincial snapshot
- Support effective knowledge management across LHINs through the implementation and expansion of technology tools to enable information sharing and collaboration

Provincial Service Accountability Agreements (SAAs) and Indicators

- Supporting the completion of the 2013-16 H-SAA and L-SAA as well as development and completion of the 2014-17 M-SAA
- Introducing process improvements aimed at continuing to improve the cycle of development and renewal of the SAAs across the 3-year lifecycle of the agreements
- Supporting a review of the current Health System Indicator Initiative (HSII) to enhance its effectiveness, and providing ongoing support to this group to ensure alignment on measurement and indicators across the system

Facilitating dialogue between LHINs and other health system partners

- Continuing to support sector and system leadership through the System Strategy Council and other forums throughout the year
- Ongoing engagement of numerous system and sector partners through more than a dozen SAA, HSII and other work groups and committees

Financial Summary

Template B: LHIN Operations Spending Plan						
LHIN Operations (\$)	2010/11 Actuals	2011/12 Actual	2012/2013 Forecast	2013/14 Allocation	2014/15 Planned Expenses	2015/16 Planned Expenses
Operating Funding (excluding initiatives)	1,403,000	1,047,588	1,335,000	1,486,250	1,486,250	1,486,250
Salaries and Wages	989,745	637,932	842,230	967,428	967,428	967,428
Employee Benefits						
HOOPP	79,097	31,979	25,971	44,695	44,695	44,695
Other Benefits	163,325	115,366	110,719	158,465	158,465	158,465
Total Employee Benefits	242,421	147,345	136,691	203,160	203,160	203,160
Transportation and Communication						
Staff Travel	778		5,000	5,000	5,000	5,000
Others	38,676	38,720	111,801	51,000	51,000	51,000
Total Transportation and Communication	39,455	38,720	116,801	56,000	56,000	56,000
Services						
Accommodation	81,208	94,094	99,878	122,718	127,398	132,111
Consulting Fees	16,547	30,370	30,000	35,500	35,500	32,582
LSSO Shared Costs		80,000	44,400	44,400	44,400	44,400
Other Services	24,616					
Total Services	122,371	204,464	174,278	202,618	207,298	209,093
Supplies and Equipment						
IT Equipment	6,734	10,058	12,000	8,200	2,544	
Office Supplies & Purchased Equipment	2,274	9,069	53,000	48,844	49,821	50,568
Total Supplies and Equipment	9,008	19,127	65,000	57,044	52,365	50,568
LHIN Operations: Total Planned Expense	1,403,000	1,047,588	1,335,000	1,486,250	1,486,250	1,486,250

Staffing Plan

Template C: LHINC Staffing Plan (Full-Time Equivalents)							
Position Title	2010/11 Actuals as of March 31	2011/12 Forecast	2012/13 Plan	2012/13 Actual	2013/14 Outlook	2014/15 Outlook	2015/16 Outlook
Senior Director	0.5	1	1	1	1		
EA	0	0	0	0	0		
AA	1.5	1.5	1.5	1	1		
Project Consultant	3	5	5	1	1.5		
Sr. Consultant	2	1	1	4	4		
Senior Business Analyst				1	1		
Communications Director					1		
Total FTEs	7	8.5	8.5	8	9.5	0	0