Toronto Central **LHIN**

425 Bloor Street East, Suite 201
Toronto, ON M4W 3R4
Tel: 416 921-7453 Fax: 416 921-0117
Toll Free: 1 866 383-5446
www.torontocentrallhin.on.ca

October 10, 2014

Ms. Kathryn McCulloch
Director
LHIN Liaison Branch
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. McCulloch,

I am pleased to present you with the Toronto Central LHIN's (TC LHIN) Annual Business Plan (ABP) for 2014/2015.

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, improving the patient experience, improving value and efficiency of health care resources and sustaining our gains. Our work also involves an investment plan for the transformation of the community sector, a significant shift towards population health planning, and the development of a system-wide focus on quality and equity.

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,

Angela Ferrante
Board Chair

Ontario
Local Health Integration Network

Toronto Central LHIN

Toronto Central LHIN

Annual Business Plan

2014 – 2015

Ontario
Local Health Integration Network

Table of Contents

Mandate and Strategic Directions

Under the *Local Health System Integration Act, 2006*, the Toronto Central Local Health Integration Network (LHIN) is mandated to plan, coordinate, integrate and fund health service providers (HSPs). The purpose of this work is to improve the health system for residents who live in communities within our geographic boundaries.

There are three documents that guide the strategic and operational priorities of the LHIN:

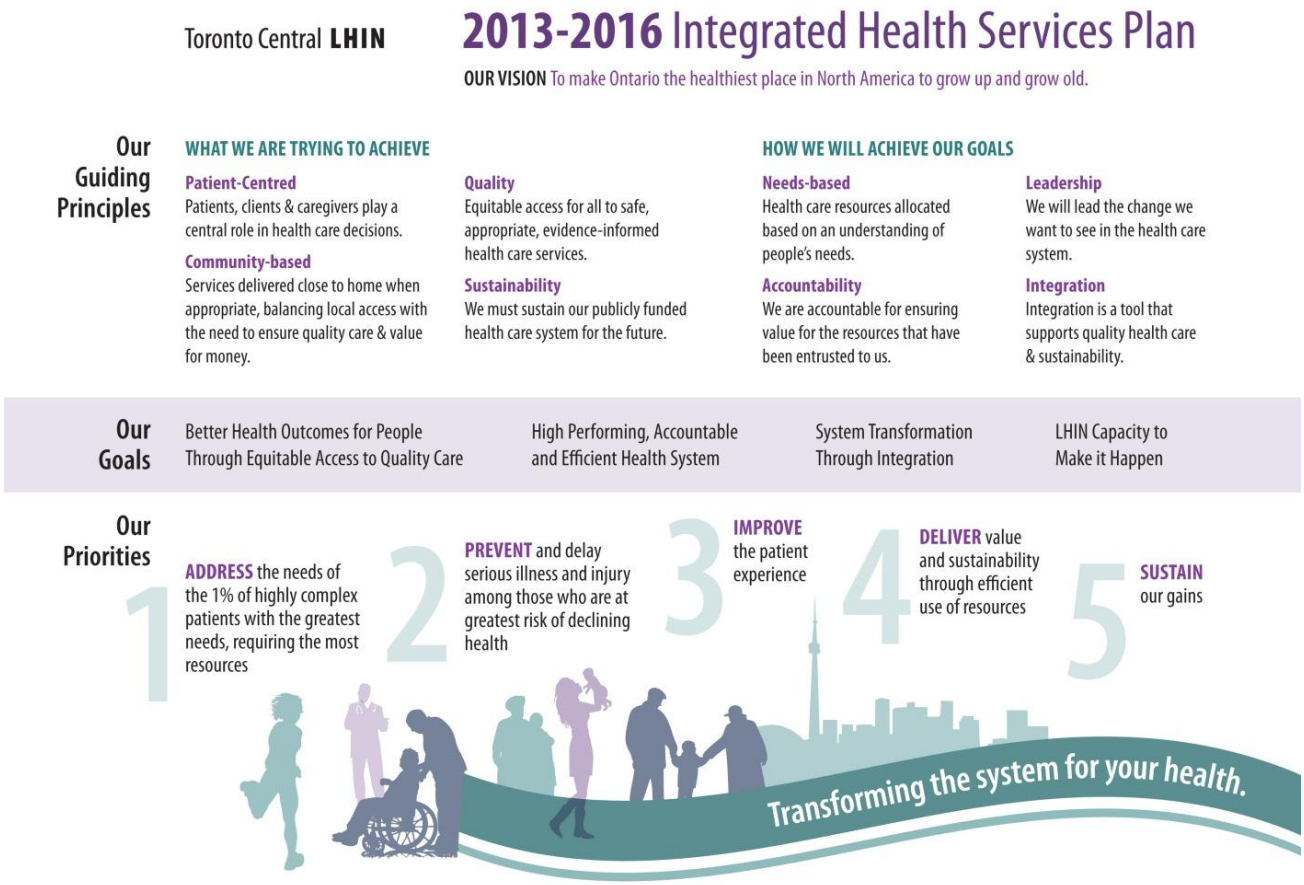
- Integrated Health Service Plan 3 – (IHSP-3)
- Annual Business Plan (ABP)
- Ministry LHIN Performance Agreement (MLPA)

Every three years, the LHIN develops the Integrated Health Service Plan (IHSP) through consultation with the local community (including HSPs and their boards, consumers of health services and the public), the IHSP outlines LHIN priorities to achieve its vision and meet its mandate of integrating the health care system at the local level. The Toronto Central (TC) LHIN's 2013-2016 Integrated Health Service Plan, or IHSP-3, sets the course for the health system over the next three years.

Our IHSP-3 builds on the directions in the Minister of Health and Long-Term Care's Action Plan for Health Care and supports major provincial directions, such as Health Links.

The MLPA establishes Ministry expectations and metrics by which the LHIN progress will be measured. The ABP connects the strategic and operational activities, laying out the three-year road map to achieving the goals and priorities established in the IHSP 3.

The Annual Business Plan is the more detailed plan of initiatives the LHIN will implement in a 12-month period to achieve the goals of its IHSP, and meet its MLPA commitments. The Agency Establishment and Accountability Directive requires that the LHIN, as a provincial agency, be accountable to the government for using public resources and that a business plan be produced annually. The 2014-2015 ABP is driven by the Toronto Central LHIN's five IHSP-3 Strategic Priorities that address the most urgent local health needs and offer the greatest opportunity for system change to meet our goals for patients.



Overview of Current and Forthcoming Programs

Overview by Sector:

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

- 17 hospitals with a total of 2.19 M patient days.
- 17 community health centres (CHCs) providing an estimated 423,511 face-to-face encounters (YE 2012/13).
- 67 agencies providing community support services (CSS) totaling an estimated 889,054 community visits and 965,490 resident days.
- 69 agencies that provide mental health and addictions (MHA) and problem gambling services totaling an estimated 1,252,623 visits.
- 1 Community Care Access Centre (CCAC) providing an estimated 3,608,048 visits/hours of care and case coordination.
- 36 long-term care (LTC) homes accounting for almost 6,386 approved long-term care beds (equivalent to 2,323,176 days).

The TC LHIN's base transfer payments budget is $4.66B

HSP Budgets 2013/14	Base	One time	Total	% of Total Funding
Hospital	3,453,312,877	88,327,992	3,541,640,869	75.96%
Grants-MunTax-Public Hospitals	749,025		749,025	0.02%
Long Term Care Homes	262,158,018	77,264	262,235,282	5.62%
Community Care Access Centres	217,768,937	2,961,618	220,730,555	4.73%
Community Support Services	79,932,813	2,003,765	81,936,578	1.76%
Asstd Living Serv-Supportive Housing	47,507,257	1,487,704	48,994,961	1.05%
Community Health Centres	92,634,898	(27,008)	92,607,890	1.99%
Community Mental Health	107,599,627	1,629,061	109,228,688	2.34%
Addictions Program	29,059,275	642,357	29,701,632	0.64%
Specialty Psych Hospitals	258,041,693	30,000	258,071,693	5.53%
Grants-MunTax-Psych Hosp	49,050		49,050	0.00%
Acquired Brain Injury	1,813,572	81,984	1,895,556	0.04%
Initiatives	17,995,498	(3,248,016)	14,747,482	0.32%
Total	**4,568,622,540**	**93,966,721**	**4,662,589,261**	

Overview by Priority:

I) Address the needs of the 1% of highly complex patients with the greatest needs, requiring the most resources.

Priority Description:

Some diseases are very costly to treat. While detailed Ontario costing figures are not currently available, the trend in Ontario confirms what is seen in other jurisdictions with respect to the concentration of costs on a very small portion of the population. Studies have shown that individuals with just one chronic condition are twice as costly to the health care system as an individual who is chronic disease free. That proportion rises to fourteen times for those with five or more chronic health conditions.

In Ontario, we know that "one percent" of the population accounts for approximately one-third of health care costs. Sustainability of the health care system is dependent on efficient and effective management of the resources that we have. This will ensure that we can continue to invest in high quality services and strategically target our resources to where they will be most effective and have the greatest impact.

Despite the high cost of caring for this population, too many patients in this group are not receiving appropriate care. Often they are living and deteriorating in hospital because they cannot get access to other health services. While many of the costs are unavoidable, the LHIN will focus on making improvements to the coordination and appropriateness of care, ensuring that these individuals are accessing long-term care, hospices, rehabilitation or home care in a timely fashion. The LHIN will focus on particular groups within the one percent population to target efforts and achieve improvements to care and efficiency. This group includes: frail seniors, palliative care patients, medically complex children and people living with serious mental health illness and addictions.

II) Prevent and delay serious illness and injury among those who are at greatest risk of declining health

Priority Description:

Five percent of the population – including people living with multiple chronic conditions, but not yet falling into the category of highest users of the system. With the right supports and services these individuals can often maintain their health and independence. Patients in this group tend to have multiple chronic diseases and use multiple parts of the system. These patients require ongoing primary care to help them to maintain their health and manage their conditions. Nearly 70 percent of seniors who receive home care are living with multiple diseases, and while they may be coping, they are at risk of reaching a level of complexity that will move them into the category of highest users. Caregivers play an indispensable role in helping these individuals with their daily needs. Patient self-management programs can also improve their health and quality of life. A strong primary care system that is well integrated with community health services, acute care and other services and providers in the continuum is the cornerstone of our plan to improve the health and reduce the burden of illness in highly complex patients.

III) Improve the Patient Experience

Priority Description:

We aim to design services based on what people need and say is important to them. Over the next three years, all health service providers will begin to measure and report on how they are improving the patient's experience.

Patient input will be integral to all the initiatives that the TC LHIN leads and funds. As part of this, we will make certain that we 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. In an effort to ensure patients are at the centre of the health care system, the TC LHIN has brought together several working groups to plan and implement improvements to care for several different at-risk populations. These working groups are looking into the timeliness, quality and access to care issues that our target populations face.

Our work in improving the patient experience spans a number of populations and includes children and youth, those living in long-term care, those receiving care in the community, those receiving palliative care services and those living with mental health and addictions. Since timeliness of access to services is an important way in which the public describes their experience, our work to reduce wait times continues as well.

IV) Deliver value and sustainability through efficient use of resources

Priority Description:

Extracting the highest value for the public from all of our investments is a key theme underlying the way in which the LHIN operates and invests. A publicly funded health care system is underpinned by the need for efficient use of resources, and ensuring that Ontario's health care system is both effective and efficient as a result of policy choices and effective management. This is a key priority in the Strategic Plan for the TC LHIN work; recognizing that without effective management of our resources, we will not be able to meet the needs of an aging and growing population.

The TC LHIN recognizes that higher quality care and lower costs must go hand-in-hand. This priority is about making existing resources in the LHIN go further. It is about working smarter, together. We will focus on two areas. The first is on strengthening the capacity of community-based health care services to respond to the needs of an increasingly complex group of seniors. Today's seniors are living longer and want to be as active and self-reliant as possible. Creating and sustaining a robust system of services in the community not only reflects what patients desire in terms of location of care, it is also more efficient than institutionalized care. Our second focus is on better integrating key clinical services in order to improve patient outcomes at the same or lower cost. We are starting with reorganizing stroke, hip and knee rehabilitation services. Through integrating and enhancing inpatient, outpatient and community services across Toronto and the GTA, patients will improve their health outcomes and improve their experience with the health care sector. We will also integrate wound care and other

clinical services identified by health service providers for which we are not currently meeting evidence-based best practices.

V) Sustaining our Gains

Priority Description:

As the LHIN develops and refines the population health approach, we will gain an improved understanding of the diverse communities that make up the LHIN so that we may tailor services to the areas of greatest need. While this represents a shift in our planning approach, the intent is to create the conditions in which the gains achieved over the last seven years might be sustained and spread across our local region.

The LHIN has demonstrated that a coordinated system-wide response to systemic challenges such as ED Wait Times, and the number of patients waiting in Alternate Level of Care can produce positive results. These gains are made possible through strong performance management with health service providers, planning that spans boundaries and sectors and the development of targeted interventions that address gaps in the system where patients find themselves falling through the cracks. This priority describes the active management of our gains on key performance metrics, the work undertaken to transform the way in which we plan for the whole population to create greater equity of access to services and the leverage of tools such as technology to create system sustainability.

Environmental Scan

Imperative for System Transformation

Significant health system reform is required regardless of the economic situation. The demand for health care services and costs will inevitably rise as the population grows and baby boomers reach an age when they will need more health care.

Today, people are living longer and with more complex health conditions. The aging population with multiple chronic illnesses seeks most of its care in the community, largely using primary care as a gateway to the care and services they need. The importance of community care is on the rise as we work to support healthy aging and living at home for as long as possible.

The design of the health care system today is largely attributed to the way that it evolved. The majority of infrastructure was built in the 1950s, when we had a young, healthy population and episodes in the hospital were short and acute in nature. The presence of a strong and vital acute care system will always be a defining feature of a world class health care system, and hospitals must be able to focus on what they do best: provide acute care.

Building and strengthening the community sector will unlock many solutions for better quality, greater sustainability and a better patient experience. Investing in the community, while sustaining a strong

acute care system is key to system transformation and this critical task has fallen to the LHINs. By designing the system around people's needs and improving how it works for them, we achieve better value for the resources that are dedicated to improving the health of our community.

TC LHIN's 14/15 plan identifies the most important actions that need to be taken to improve our uniquely urban health care system and respond to the changing needs of the people served in our LHIN. Through extensive consultation and engagement with clients and families, providers and system leaders, it is evident that the system of care must change – not within the silos, but as a system of care. While providers have led changes and sought to transform their organizations, and some have even introduced changes that span multiple organizations, change must occur at a faster pace, and in a more integrated manner to meet the new challenges facing community based health services.

Drivers for change include: radically evolving service needs; demands and opportunities for innovation; new possibilities for where services can be delivered; and patients' and providers' growing expectations that services can and should be delivered at a higher level. Each driver for change is expected to grow significantly in the coming years.

Recognizing the breadth of the factors that contribute to health outcomes, a portion of LHIN resources has been dedicated to building the foundation upon which a newly transformed health care system will rely. This work involves:

- an investment plan for the transformation of the community sector,
- a significant shift towards population health planning, and
- the development of a system-wide focus on quality and equity.

Enabling System Transformation by Strengthening the Community Sector

There is a clear need for enhancing access, services and care coordination for our most complex and at-risk populations. Individuals receiving care by family physicians demonstrate better health outcomes and lower rates of premature death due to chronic diseases. Yet the most complex clients with the greatest needs are often the ones the health care system is failing the most. And as needs of complex clients extend beyond any one sector or provider, there are greater challenges to integrating care.

The system of care is not truly acting as a system, but rather as a group of silos, thereby creating an opportunity for greater integration and partnership. The LHIN's Community Transformation Agenda is an opportunity to make significant change with respect to how our most complex and at-risk populations receive integrated care through a model where providers work together seamlessly for the client. To enable this change, a shift in mindsets is required. This includes:

- *A focus on the needs of the most complex clients and those at-risk of becoming complex*
- *All work is guided by a goal to enhance sustainability of services, not organizations;*
- *A shift from across the board increases to focused targeted investments to address critical needs.*
- *New approaches to solution development and deployment are required and entities will be held to increased levels of accountability for delivery*
- *A focus on supporting partnerships where providers come together to address needs in a coordinated, efficient fashion to create added value for the client and/ or for the system;*

- *An increased focus on accountability – to the client, sector partners, across sectors, public;*
- *An expectation of greater levels of monitoring and evaluation to enhance impact and benefits to clients;*
- *A focus on building community capacity, including the ability to advance and sustain required system changes*

While transformation planning efforts to date have helped to identify and inform investment priorities, they have also helped to identify areas where additional planning can further support transformation goals. These will be considered areas of focus for subsequent years, and will inform future investment plans.

Community Investment Plan

To ensure the TC LHIN's populations with the greatest need for health care services are supported, we must focus our efforts to bring forward system change to support people where they live. The goal of developing a community investment plan is not simply about improving service volumes, but also about re-thinking how, where, and why care is delivered. The need to consider and reflect on the supports and capabilities that our community health service providers have and/or require to more effectively address local population needs identified is acknowledged.

Integrated care can only be achieved when sectors work together, across historic and artificial boundaries to provide appropriate care the client wants, by the right provider, at the right time. As such the LHIN's transformation planning efforts have been well informed through extensive stakeholder engagement including clients (e.g. seniors, those living with mental health and addictions issues, and/ or their caregivers), health service providers, community provider boards, other LHINs, the Ministry of Health and Long-Term Care and representatives from other Ministries, and other funders such as the City of Toronto and the United Way.

To further support the transformation planning, the LHIN struck four different working groups with representation from sector experts. These groups have met and developed blueprints for how complex and at-risk populations can be better supported through greater alignment and linkages across the primary care, community support sector, mental health and addiction sector, and the hospital sector. The proposals and recommendations prepared by these working groups are helping to inform the LHIN's priority setting and investment planning process.

Population Health Planning and Equity

The focus in health care is changing. It is moving from a system that was planned around providers, their preferences and roles, to that of patients. Understanding the needs of patients and populations has become paramount, and that understanding is beginning to drive health care design.

The Excellent Care for All Act was a statement to the health care system, that everyone, regardless of who they are or where they live should have access to high quality care.

The TC LHIN is committed to this value and is working to ensure that every individual, regardless of gender, race, income or social status, has the same access to high quality health care. It has become the

organizing principle around our system transformation objectives and it is helping to anchor our thinking and orientation as the system moves forward to meet the needs of the population.

Local demographics, socio-economic and cultural factors play important roles in identifying community priorities; geography and local resources can have a big impact on how services are delivered. As regional planners, the LHINs are able to engage local neighborhoods to understand the diverse sets of needs that may be attributed to a population in order to assess potential service gaps, access or equity issues. Taking a population health planning approach and developing comprehensive services for these sub-LHIN populations is a practical approach to addressing the health needs of these communities.

Looking at the Integrated Health Services Plan priorities from a regional level has enabled us to align the work of a diverse group of providers, both health and non-health, and ensure that the decisions of individual organizations are not made in isolation. It has also created the conditions for scaling up innovations that are demonstrating with one set of providers, across all sectors and providers. Leveraging the Health Links model, each Link has identified a focused priority population for which to plan and deliver integrated services. The solutions for those populations, such as mental health and addictions, children and youth and frail seniors, are being incubated and tested and once results are demonstrated, they are shared across all Health Links partners.

Risk Assessment

TC LHIN is the only LHIN in Ontario that is completely urban. With 1.15 M residents, the TC LHIN is an extremely diverse area in terms of the population who lives there and the hundreds of thousands who come to the city for health care. There are vast differences in incomes and educational levels in Toronto, ranging from some of the most affluent neighbourhoods in Canada to some of the poorest. Twenty-four percent of the population is low income and there are over 5,000 homeless people in the LHIN.

It is estimated that 42 percent of the population is 20 to 44 years old and 13 percent of the population is aged 65 years and older. By 2016, seniors will account for 14.8 percent of the LHIN's population with many becoming increasingly frail as they age. The Baby Boomers are reaching an age where they will need more health care. The majority of people who are Alternate Level of Care in a hospital are over 75 years old. Similarly, seniors visit Emergency Rooms (ER) more than the rest of the population.

While newcomers contribute to the wonderful diversity of the city, they face barriers to care, particularly if they are unable to speak English. Today 4.2 percent of the population reports no knowledge of either official language. The City of Toronto is also home to approximately 19,265 people who self-identify as Aboriginal. 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 58,380 (10.5 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.

Key Risks:

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 (e.g., those with 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 of repatriating patients back to their home LHIN contributes to budget pressures and ALC rates and impedes patient flow in the TC LHIN.

In 14/15 the new Life and Limb Policy will be implemented across the province. This policy expedites appropriate care at appropriate locations for critically ill patients. One aspect of the new policy is effective repatriation of patients once they are stabilized. CritiCall is initiating a repatriation tracking system to facilitate this part of the policy. We are hopeful that this identifies opportunities for improved repatriation processes for appropriate patients.

Inflationary pressures and balanced budget challenges

Despite 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’ ability to sustain clinical and other programs at current levels.

Integrated Health Service Priorities

ADDRESS the needs of the 1% of highly complex patients with the greatest needs, requiring the most resources

Current Status

Health Links

Health Links is an innovative approach that brings together health care providers in a community to better and more quickly coordinate care for high-needs patients. The LHIN has been leading a planning effort in conjunction with our local Hospitals, Community Support Service Agencies and Community Mental Health and Addictions Agencies, with a goal of helping to streamline and improve access to services offered by these providers. Particular emphasis has been put on identifying and addressing the needs of the complex population and the at-risk population. This work has included over 20 meetings in collaboration with three Health Links Working Groups that were struck to support this effort: CSS Working Group, CMHA Working Group and Hospital Specialized Services Working Group. Stakeholder engagement activity was conducted and included a series of client engagement sessions, meetings with each of the LHIN-funded health care sectors and a meeting with MPPs. To further inform the LHIN's Health Link planning process, a 'think tank' was hosted with approximately 100 providers from various sectors, other funders (e.g. United Way, City of Toronto), primary care providers, Ministry staff, representatives from other LHINs and TC LHIN Board representatives. This feedback was then shared with the various working groups and integrated into their design work.

The LHIN has taken a regional planning approach to a number of other initiatives intended to help support the work of the various Health Links, to meet their business needs and to help advance the program's strategic aims. This approach will help to avoid duplication of effort, promote efficiencies and leverage economies of scale. These initiatives are intended to build related processes and infrastructure only once and to make corresponding services available to Health Links as they move to implementation. Taking a regional approach helps to coordinate design efforts, avoid overlap and optimize existing resources. Such initiatives include but are not limited to:

- *Implementation of a standardized discharge summary,*
- *Development of an integrated decision support system,*
- *Implementation of a number of coordinated access points to help support referrals to services required by complex and at-risk patients*

To further complement the work of our Health Links, the LHIN is collaborating with other funding partners, and with providers who have planning accountability for specific populations to identify areas of focus that will help to address the needs of at-risk populations and with an emphasis on population health. The Strategic Advisory Group will help to identify both short-term and long-term opportunities and will help to identify and address barriers and key issues. Addressing the needs of Children and Youth (particularly transitional age youth and youth with Mental Health and Addictions issues), promoting elder-friendly communities and health promotion/building a healthy city, have surfaced as potential areas of focus.

The LHIN is working closely with the TC CCAC to support the development and implementation of various initiatives that are designed to benefit the work of the various Health Links. Included below are four examples:

- The Community Navigation and Access Program (CNAP) is a network of over 30 community support service agencies serving seniors across the Toronto Central LHIN that helps them maintain their independence and live at home with the supports they need. A toll-free phone number (1-877-540-6565) provides a single access point to for anyone unsure of where to turn for community support services ranging from adult day programs to transportation to caregiver support to counseling.

- Callers are greeted by a professional Social Worker who takes the time to understand each senior's needs and connects the senior to the right services in the community. This is a significant help for seniors in our communities but also for family physicians who need to connect senior patients with community support services. CNAP also makes it easier for support staff, discharge planners and hospitals to gain the information they need about available services to support seniors to transition back to their communities after a hospital stay.

- Access 1 directs people to the appropriate mental health services making it easier for individuals, families or physicians to access care in the TC LHIN and through other GTA-LHIN agencies. When a client or a family member calls Access 1, the highly trained health care professional provides them with resources and sets them up with a standardized application form for services including case management services and specialized Assertive Community Treatment Teams (ACTT).

By providing short-term assistance to individuals and managing a standardized form, Access 1 is able to streamline the system, relieve pressure on service providers and most important, enhance the experience for the clients, families and physicians allowing more time and resources to be allocated towards the care of the person in need. In its first year, 742 individuals were served by Access 1 and 23 mental health services were considered partners.

Goal(s):

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.*

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	**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.**					
"We will deliver the following"	**2014/15**		**2015/16**		**2016/17**	
	Status	**%**	**Status**	**%**	**Status**	**%**
Health Links Community Health Leadership Project: • Two distinct leadership programs (Community Health Leadership Program and Advanced Health System Integration Program) to be offered to a total of 115 TC LHIN emerging and current community leaders • Peer/mentorship program to be developed and deployed to ensure sustainability • Goal is to build and enhance leadership capacity in community sector by equipping leaders with the skills required to achieve successful system level outcomes	Completed	100%				
Health Links The development of the 9 Health Links continues in 2014-15. Specifically the 4 Early Adopters will complete their first year of implementation (in July 2014) . They will build on their work to create a work plan for year two focused on the key deliverables related to improved patient outcomes. Wave 2 and 3 will also begin the work of initiating projects aimed at achieving HL goals.	In progress	75%	Completed	25%		

Health Links: Foot Care Service Delivery Pilot Project in West Toronto Health Link • Four Villages CHC and the Michener Institute will work in partnership to provide placements for chiropody students with the goal of enhancing access to foot care services for clients with diabetes residing in West Toronto • Model to expand over time to include provision of comprehensive diabetes care involving students from other health care disciplines (e.g. nursing, pharmacy, dieticians) • Pilot to help inform future curriculum development and community placement opportunities • Aim is to expand access to comprehensive diabetes services in high risk communities by spreading the model to other underserviced areas in the future	In progress	75%	Completed	25%		
Health Links **Essential Influenza Vaccination for at-risk and complex older adults in high priority neighborhoods (placeholder)** • To plan for dissemination of the Influenza immunization initiative piloted in 2 high priority neighbourhoods in 13/14 to other high priority neighbourhoods • Project goals are to increase awareness around Influenza vaccination and increase vaccination rates amongst at-risk and complex older adults residing in high priority neighbourhoods	Completed	100%				
Palliative Care Plan Implementation • Strengthen service capacity in the community and long term care settings to reduce	In progress	50%	Completed	50%		

hospitalization • Broaden access to palliative care services by establishing early identification protocols, and focusing on access to palliative care services across sectors • Improve integration of services through integrated care teams, and system navigators • Strengthen caregiver support services						
Long Term Care Outreach Supports Plan Implementation • Identification and coordination of specialized resources into LTC to care for older adults with mental health and/or behavioural conditions.	In progress	80%	Completed	20%		
Implementation of community psychogeriatric services plan to improve capacity and access	Completed	100%				
Implementation of the Integrated Care Model for individuals with complex mental health issues. Two models will be implemented to bring together ACT teams, Intensive Case Management services, counselling, peer and family supports within a client centred service plan. The model will be implemented in two sites: • Reconnect Mental Health Service • St. Michael's Community Mental Health	Completed	100%				

How will we measure success?

- Reduce the cost of services utilized by the one percent population.
- Reduce unscheduled inpatient readmissions within 30 days of discharge for selected Case Mix Groups (CMGs).
- Reduced total number of acute hospital days attributed to palliative care.

What are the risks / barriers to successful implementation?

- Change management is a significant component in the planning and implementation of new models of service delivery or a test of change initiatives. Retaining the commitment and buy-in from the major stakeholders involved in the initiatives described above throughout the planning and implementation of new initiatives will help ensure success. TC LHIN will continuously engage the health service providers and clients/patients, wherever possible, to mitigate any erosion of major stakeholder commitment to the success of the initiatives above.
- The high number of solo practitioners in TC LHIN will present a challenge in reaching out and engaging and linking them to local health links.

Integrated Health Service Priorities

Prevent and delay serious illness and injury among those who are at greatest risk of declining health.

Chronic Disease Management

The Toronto Central LHIN and its partners will work together on improving chronic disease prevention and management and will be developing a LHIN-wide diabetes program, first with a multi-faceted approach to care for diabetes that can be implemented across other chronic diseases. The main focus of the plan will be to establish a LHIN-wide diabetes program that will include:

- *Coordinated referral of people with diabetes to diabetes education programs;*
- *Engagement of primary care physicians;*
- *Dissemination and uptake of the new Canadian Diabetes Association clinical practice guidelines;*
- *Monitoring of Diabetes Education Programs; and*
- *Establishing linkages with hospital-based and Family Health Team-based diabetes programs.*

Efforts will be directed at ensuring people with diabetes receive services of high quality and in a comprehensive and integrated manner across the LHIN. Furthermore, people with pre-diabetes and diabetes will be supported to learn how to best care for themselves. These efforts will help prevent further complications and lessen the impact of this serious health issue. Better chronic disease prevention and management can contribute to better health, reduced hospital readmission rates and a reduction in avoidable hospitalizations.

Several quality improvement initiatives are underway, including the a centralization of service referral across the LHIN, the establishment of standardized insulin protocols, support for Diabetes Education Program accreditation through the Canadian Diabetes Association, and a coordinated professional development strategy for health professionals.

Additionally, three outreach and screening programs are serving residents from across the region (operating out of Unison Health and Community Services, Flemingdon Health Centre and Anishnawbe Health Centre) and providing culturally relevant and linguistically appropriate services.

Finally, technology and telehomecare will be increasingly leveraged over the coming years to support clients living at home with a chronic disease to improve self-management skills, symptom management, and communication and collaboration among care team members.

Goal(s):

Integrate primary care with all providers within local communities so that providers will be collectively responsible for ensuring people living in their area receive needed services and for improving their health outcomes and experience. As a result:

- *Every resident will have a primary care practitioner who provides them with accessible, high-quality care regardless of which practice model they are in.*
- *Residents have access to an interprofessional team or network of providers who work with their primary care practitioner.*

Consistency with Government Priorities:

This priority is closely aligned 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 of a fully integrated system.

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.**					
"We will deliver the following"	**2014/15**		**2015/16**		**2016/17**	
	Status	**%**	**Status**	**%**	**Status**	**%**
Chronic Disease Management – Implementation of a multi-year Chronic Disease Framework that will focus on Diabetes, COPD & Asthma, and Vascular disease. The Framework will bring together TC LHIN initiatives under the Diabetes Early Detection and Education Programs: Telehomecare, Telemedicine	In progress	33%	In Progress	33%	Completed	33 %

and TeleOphthalmology programs, and will be supported by TC LHIN work on community rehab, exercise and falls, and palliative care.						
Expand coverage of the Mobile Crisis Intervention Teams (MCIT) across the City of Toronto. This initiative will also include developing standardized training, protocols, - and practices for the teams when responding to emotionally disturbed individuals. The anticipated result is fewer transfers to hospital emergency departments.	Completed	100%				
Assess Restore policy In 13/14 the MOH introduced a new policy and funding stream to target frail seniors in the community. This built on recommendations from the Sinha Senior Report. The TCLHIN received 13/14 funding and many of our providers were able to mobilize strategies and programs to develop innovative ways to care for this target population in the most appropriate setting - and avoid ED and acute care admissions.	In progress	50%	Completed	50%		
Rehabilitation services In 13/14 the MOHLTC and the LHINs collaborated on a significant Physiotherapy Reform Program that removed services from OHIP and realigned and expanded them into other existing structures. Now that the transfer is complete the TCLHIN wants to ensure that this investment achieves the greatest value and is fully integrated with other community-based rehabilitation services. The goal is to develop a plan for rehabilitation service delivery in the community and across the continuum that meets the needs of the community including people with chronic diseases, people with disability and frail seniors.	In progress	50%	Completed	50%		

How will we measure success?

Reduce the cost of services utilized by the one percent population.

- Increase the percentage of people in the target groups with primary care provider (percentage of vulnerable complex patients attached via Health Care Connect and CHC)
- Reduce the percentage of repeat unscheduled ED visits (within 30 days for Mental Health, Addictions, and selected CMGs)

What are the risks / barriers to successful implementation?

- The expected results will need to be measured over implementation and over several years. With competing priorities that will emerge over time, there is a risk of health service providers shifting attention to other initiatives. Mitigation of this risk will include continuous engagement and re-focusing health service providers on the goals of these initiatives.

Integrated Health Service Priorities

Improve the patient experience

Children and Youth Services

Care coordination and navigation is a challenge for medically complex children, particularly teenagers moving from the children's to the adult health care system. While these children have a variety of medical conditions, they are experiencing similar issues, including dependence on medical technology, and the need for highly specialized care. Their care needs also place substantial demands on their families and the health care system over many years and often into adulthood. These challenges are compounded when children and families do not speak English and are not knowledgeable about how the health system works.

Under the leadership of Holland Bloorview and SickKids, the Children and Youth Advisory Table (CYAT) submitted their final report in December 2012, which includes recommendations to improve services for medically complex children and their families. Recommendations include:

- *Development of cultural competency training modules;*
- *Development of pediatric and youth-specific information for the soon-to-be launched healthline.ca;*
- *Activities to expand and operationalize the integrated complex care model for medically complex children, and;*
- *Development of a transitional clinic program at Holland Bloorview and Anne Johnson Health Station for youth with Spina Bifida.*

Additionally, the development of a Caregiver Framework for Children with Medical Complexity is led by the Hospital for Sick Children in partnership with the Toronto Central Community Care Access Centre and Holland Bloorview Kids Rehabilitation Hospital. This program provides health and social supports to

family caregivers of children with medical complexity, who are considered 'at risk' as a result of their caregiving activities.

Long-Term Care

The Toronto Central LHIN has among the fewest long-term care beds for its population (12th lowest of the LHINs). Even though the LHIN also has one of the lowest rates of demand for long-term care, access is a significant issue. Currently, LTC homes are at 103.3% occupancy and the median time for a client to be placed in a long-term care home is 89 days.

There are 36 long-term care homes in the TC LHIN. Nineteen of these long-term care homes are older and have been identified by the Ministry of Health and Long-Term Care as needing to redevelop by 2025 in order to meet the current Ministry design standards. Given the high cost of land and construction costs in Toronto, several of these long-term care homes have informed the TC LHIN that they will not be able to redevelop within the LHIN. TC LHIN staff has and will continue to, raise the issues with the Ministry that are preventing homes from rebuilding in this LHIN. TC LHIN staff will also continue to work with the older homes to explore possible options for redeveloping within the TC LHIN.

The Behavioural Supports Ontario strategy is led in the Toronto Central LHIN by Baycrest Centre for Geriatric Care with a 23-bed transitional specialized unit at Baycrest that provides time-limited, specialized support for seniors whose behaviours have become unmanageable in their current setting, outreach teams that work collaboratively with Long-Term Care and community providers to build capacity and support residents with behavioural issues. The program also includes an education consortium that provides behavioural support training and education to community providers, outreach to primary care physicians and support to caregivers.

Mental Health and Addictions

Enhanced service models are required to create a continuum of integrated services that will provide evidence-based interventions to meet the immediate and changing needs of complex mental health and addictions clients. The proposed models will provide for service coordination and team-based care for the most complex clients, flexibility to increase and decrease the intensity of service as required, timely access to service and a network of partners to provide seamless access to additional key services. The specific service models are to be tested with the early Health Link adopters (South Toronto and Mid East Toronto Health Links).

The Mental Health and Addictions Sector Working group has recommended a fully integrated access point for mental health and addictions services, resulting in a more effective, efficient and seamless access system for clients, their families and their primary care providers. In addition to extended hours of service, a physical location for in-person service and a highly skilled phone response team, the access point will have a fully integrated information technology and administrative back office. The access point will evolve to be integrated/linked to other important access points including developmental services, youth mental health, Community Support Services, Centre for Addiction and Mental Health, etc. Current integration efforts have already led to more unified services for clients. To support the goals of the Mental Health and Addictions Sector Working Group, the Access steering committee will now move forward with identifying and implementing an approach to prioritize access to key services for the complex population.

The Toronto East General Mobile Crisis Intervention Team (MCIT) has successfully launched and is fully operational with 5 MCITs operating across The City of Toronto. The Mobile Crisis Intervention Team Steering Committee, co-chaired by Toronto Police Services and Toronto East General Hospital, submitted a final report including a number of recommendations in an effort to expand this project across all five GTA LHINs, which is now under consideration.

As part of a comprehensive project to move long-stay Mental Health and Addictions clients from hospital to the community, three new services were launched, including:

- *11 High Support Housing Units – for clients with significant behavioural, mental and physical health issues. Additional high support capacity is being generated through a "flow" strategy, whereby tenants in high support housing units who are ready to move to lower support settings are being supported to move to "step down" units.*
- *14 Step Down Supportive Housing Units – created to support the flow of high support tenants to the right place of care.*
- *Transitional Support Teams - A multidisciplinary team has been built to support the transition from hospital to the community, as well as from high support to lower support housing units.*

Additional housing supports for complex mental health and addictions populations have been established through a partnership between the TC LHIN, Toronto Community Housing, Houselink Community Homes, Fred Victor, Inner City Family Health Team and the Toronto Police Services. By adding security and two community mental health and addictions staff, Toronto Police activity was significantly reduced in the building, security incidents were reduced and costs related to damages and vandalism were reduced. A significant number of tenants are participating in group activities and are being referred to services provided by other key external agencies. The project is being presented at an upcoming Ontario Non-profit Housing Conference. It is also under discussion as part of a City of Toronto-led George Street Renewal process.

Palliative Care Planning

The TC LHIN is redesigning palliative care services to support the best possible end-of-life experience for people and reduce the cost associated with hospitalization of palliative clients. This strategy 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.

Implementation of the Palliative Care Plan will begin in April 2014. A Palliative Care Steering Committee has been established to provide advice in the development of the plan. Palliative Care planning efforts will also leverage the work currently underway in the development of a central bed registry aimed at reducing Alternate Level of Care days in acute care and ensuring timely access to a palliative care bed.

Community Support Services

In an effort to create an integrated access point for seniors, the Community Navigation and Access Project implemented a pilot for a collaborative call centre between the Community Care Access Centre and Community Navigation and Access Project. Community Navigation and Access Project is also developing a common tool for determining the financial capacity of clients in an effort to improve equitable access to community support services across the network of agencies.

Community investment funding was assigned to the Enhanced Adult Day programs to allow the agencies to apply the service standards consistently across the TC LHIN. The TC LHIN will also release a call for proposals to add an additional Enhanced Adult Day program in the west end of the LHIN, where there is an identified gap.

The Community Support Services Health Links Working Group identified Caregiver Support as a key service to address the needs of complex seniors. As such, the TC LHIN will plan for the expansion of this service through the existing program provided through the Alzheimer Society, which provides individualized supports to address the caregivers' care plans.

The TC LHIN is also beginning the planning, training and implementation of a collaborative transportation system throughout 2013/14. The goal of this transportation planning is to develop a transportation system, currently comprising approximately 15 individual providers, wherein all providers are using the same software for scheduling rides, no clients will be rejected for a ride, all rides are confirmed at the time of request and the cost to the client is competitive with commercial taxi service rates. Essentially, the TC LHIN will move transportation services from being operated separately by 15 providers, to 15 providers functioning as a single transportation system.

Reducing 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.

The TC LHIN is pleased to report that it is meeting targets for the following performance indicators:

- *90th percentile Emergency Room(ER) length of stay for admitted patients*
- *Percent of Priority IV Cases completed within access target for Cancer Surgery*
- *Percent of Priority IV Cases completed within access target for Cardiac By-Pass*
- *Percent of Priority IV Cases completed within access target for Cataract Surgery*
- *Percent of Priority IV Cases completed within access target for Hip Replacement Surgery*
- *Percent of Priority IV Cases completed within access target for Knee Replacement Surgery*
- *Percent of Priority IV Cases completed within access target for MRI Scans*
- *Percent of Priority IV Cases completed within access target for CT Scans*
- *Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*
- *90th percentile Wait Time from Community for Community Care Access Centre In-Home Services – application from Community Setting to first Community Care Access Centre service (excluding case management)*

The TC LHIN has not met targets for the following indicators but there is an improvement compared to 2013/14 baseline:

- *90th percentile Emergency Room length of stay for non-admitted complex patients*
- *90th percentile Emergency Room length of stay for non-admitted minor/uncomplicated patients*
- *Readmissions within 30 days for selected Case Mix Groups*

Additional wait time challenges have been identified for medical ophthalmology, upper extremity orthopaedic and foot and ankle surgery. The driver of the tele-ophthalmology strategy is the recognition that access to optometrists and ophthalmologists is difficult for individuals with diabetes who live in certain neighbourhoods within Toronto. This initiative is not intended to replace or interfere with those clients who already access similar services. Lower retinal screening rates are observed in neighbourhoods to the south, north west and east in Toronto, due to a number of barriers, one of which is likely location/convenience/transportation and possibly language limitations.

Providing screening closer to home by situating these units at strategic locations across the TC LHIN with interpretation services if necessary, will reduce the travel and communication burden for patients and their families.

The system has recently put a strong focus on total knee and hip arthroplasty because of the magnitude of Ontarians who require these surgeries. However specialized upper and lower extremity orthopaedic surgery is a service that has not had the same focus regarding wait times – and the current performance is alarming. Currently, the wait time for foot and ankle surgery in the TC LHIN is currently over 400 days, creating significant access issues for the patients who need this service. The TCLHIN is reviewing orthopaedic services in the LHIN to ensure a balanced approach to planning. The TC LHIN received targeted funding in 12/13 for foot and ankle surgery to increase capacity at two hospitals. Efforts are underway to develop a model that centralizes access and works in partnership with other providers in other LHINs.

Goal(s):

The TC LHIN is developing an ongoing process to engage people who face barriers and is developing reports based on their input that will be used for health system planning. Each year, TC LHIN will target different communities, and develop customized strategies and techniques to engage them.

Over time we will gain a more inclusive and accurate understanding of people's experiences in the local health system. Another lasting benefit is that the solutions will come from within communities and its members will become invested and active participants in creating healthier communities.

Consistency with Government Priorities:

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

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.**					
"We will deliver the following"	**2014/15**		**2015/16**		**2016/17**	
	Status	**%**	**Status**	**%**	**Status**	**%**
Children and Youth Services – Implementation of the 3rd of a 3-year set of recommendations to improve the healthcare coordination and navigation for children with medical complexity and their families, Specific goals include: • implementation of the transition model for youth with Spina Bifida	Completed	100%				

• scoping for an electronic care plan						
Integration of existing Access models. The goal is to: • complete the integration of the Coordinated Access to Supportive Housing services (CASH) with the case management access model (ACCESS 1) in the community mental health sector • complete the integration of CCAC and CNAP (Community Navigation and Assistance Program) in the seniors community support services sector	In Progress	70%	In Progress	20%	Completed	10%
Toronto Ride – Launching of a centralized scheduling and route planning for community transportation services, and delivered by decentralized health service providers. The outcomes expected are: • Trip confirmation at time of request • Advanced confirmation for regular rides • Standard operating terms for transportation providers	In Progress	50%	Completed	50%		
Orthopaedic Care Pathway and Model The TCLHIN has been working with the acute care, post-acute and community HSPs to improve care for two large orthopaedic populations – hip fracture and total joint replacements (hip & knee). This work is being done in parallel with initiatives of HQO and the introduction of Quality Based Procedures. We will complete resource reallocation that establishes ambulatory rehabilitation capacity for these populations and set up performance management framework to assess best practice. The work will continue to be refined as QBPs are implemented for hip	In progress	50%	In Progress	25%	Completed	25%

fracture.						
Stroke Care Pathway and Model The TCLHIN has been working with the acute care, post-acute and community HSPs to improve stroke care in the LHIN – mainly driven by the need to relocate resources to the appropriate setting to support best practice care. This work is being done in parallel with initiatives of the Regional Stroke Networks, HQO and Quality Based Procedures. We will complete resource reallocation and set up performance management framework to assess best practice. The work will continue to be refined as QBPs are implemented for stroke in the post-acute and community settings.	In progress	50%	In Progress	25%	Completed	25%

How will we measure success?

- *Increased percentage of providers using standardized patient experience measurement tools*
- *Improvement in TC LHIN providers' patient experience scores*

What are the risks / barriers to successful implementation?

- Fatigue of health service providers to manage change while maintaining services to clients. Few health service providers will have the internal capacity to help drive a system transformation agenda as well as maintain service delivery levels. The majority of health service providers are already stretched to provide services. They do not have any more internal capacity to actively participate in system change.
- The high number of health service providers which multiplies to a higher number of distinct services being delivered presents a risk of fragmentation of services and creates greater complexity in trying to integrate services through the Access models.

Integrated Health Service Priorities

Deliver value and sustainability through efficient use of resources.

Funding Reform and Clinical Efficiencies

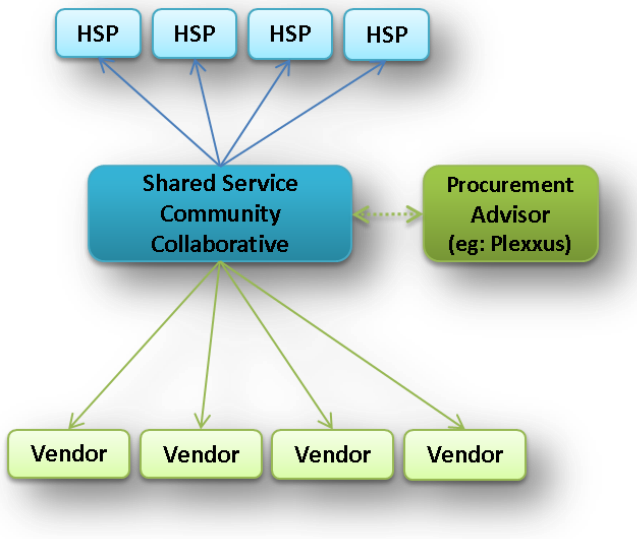
Toronto Central LHIN continues to support the move to Patient Based Funding (PBF) from predominantly global funding for its Health Service Providers (HSPs). TC LHIN continues to significantly contribute to the evolutions of Health System Funding Reform (HSFR) with the goal to improve the model by identifying issues and collaborating in the mitigation and thereby strengthening the model. Knowledge transfer has been a major commitment of the TC LHIN.

In this regard, TC LHIN continues to participate on Ministry committees and working groups. For example, the CEO is a member of the HSFR Steering Committee and the Senior Director of Performance Management is a member of the HSFR Advisory Committee as well as the Rehab/CCC, Specialty Paediatric and Home Care HSFR working groups. TC LHIN Senior Director, Performance Management also participates on the Provincial HSFR Local Partnership Committee made up of Ministry Representatives and the Co-Chairs of each of the LHIN HSFR Local Partnerships (LPs).

Over the past year, LHINs have continued to implement and strengthen their LHIN-specific HSFR LPs. These LPs are a strategic and knowledge-based group, where members are responsible to convey information to/from their partner organizations. TC LHIN's LP is co-Chaired by a Senior TC LHIN Hospital Leader and through this LP, the TC LHIN has been an active participant in monitoring and developing strategies to facilitate an effective implementation of HSFR locally and across the province and is proactively addressing the unintended consequences of the model in the short and long-term.

Quality Agenda

Toronto Central LHIN has been working with its Quality Table to define consistent indicators of patient experience. TC LHIN reviewed a large sample of patient experience and patient satisfaction tools employed by all sectors against best practice literature of measuring patient experience. As a result, TC LHIN funded the CSS sector to develop and pilot its first patient experience tool in the Adult Day Program (ADP) sector. In 2014 TC LHIN and the TC LHIN CSS sector will consider whether this will be expanded to other parts of the CSS sector. As well, TC LHIN will continue to pursue a common patient experience approach with the Ministry and Health Quality Ontario.



Shared Services for Community

Based on learning from a one-time bulk-purchase in the community, a coordinated, long-term approach to bulk purchasing has

been developed. A sector working group was formed to lead this discussion with the goal of determining a collaborative approach to purchasing, procurement and back-office support.

The agreed model identifies a Coordinator role that sits within the sector and will work with subject matter experts / partners and vendors to provide a number of services to HSPs. The proposed functions fall under one of three categories of services:

Purchasing

- *Support HSPs in researching products/services*
- *Saving through sourcing lowest cost options/best value*
- *Follow BPS directive and appropriate procurement processes*
- *Coordinate purchase cycles*

Subject Matter Expertise

- *Knowledge bank for future purchases*
- *IT assessment, knowledge, support and life cycle planning*
- *Strategic decision support and planning*

Capacity Building and Collaboration

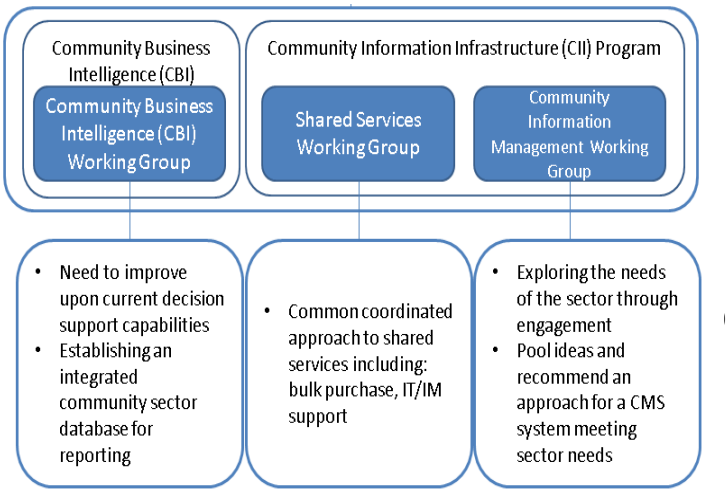
- Share knowledge across HSPs to support in purchasing
- Provide planning tools for HSPs
- Leverage and grow network of shared service SMEs (i.e. Plexxus)
- Investigate/negotiate contracts

The Coordinator's level of support will range from basic transactional services, to enhanced support, to collaborative engagements, based on the needs of each HSP. The model is scalable and designed to be implemented for various types of purchases and services, and for possible extension to agencies located outside of the TC LHIN.

In 2014/15, the newly identified Coordinating Body will execute more group purchasing and develop the infrastructure (e.g. knowledge bank) required to make the model a success. While some nominal initial funding for this initiative was provided by TC LHIN, it is anticipated that the majority of ongoing costs will be covered through savings from the joint procurements and purchasing.

Community Business Intelligence Initiative

The Community Business Intelligence (CBI) initiative will support improved decision support capability for community HSPs and the Toronto Central LHIN for the purposes of system planning and quality



improvement for the sector and the system. The CBI project will provide both HSPs and the LHIN, a single resource through which to access standard reports and enable ad hoc querying of select data elements. New questions that the TC LHIN and HSPs will be able to answer with the first phase of implementation will include:

- *How many clients are accessing the community sector (CMH&A and CSS)?*
- *How many clients and which sub-sectors/HSPs/functional centres are being accessed?*
- *Are clients accessing multiple HSPs/functional centres? What are the most common groups of functional centres used?*
- *What is the average length of stay for clients in a functional centre?*
- *What does the patient journey look like within the community sector?*

The initial test group is currently submitting data now, with full rollout scheduled to begin in early Q4 2013/14 and continuing in 2014/15.

Community Information Infrastructure Initiative

Community agencies require robust information infrastructure to support client interactions, to sustain operations efficiently, and to connect with the other parts of the health care system.

The TC LHIN offered Information Technology (IT)/Information Management (IM) Assessments to a limited number of community sector agencies. A total of 55 assessments will be conducted by Reconnect Mental Health between November 2013 and April 2014. Upon completion of the assessment, agencies will be better equipped to make smart, informed IM/IT investments, including tools and a roadmap to achieving better outcomes with technology. Insights garnered from the assessments will help inform the planning and development of an IT services strategy and approach for the sector.

Risk Assessment

There are currently over 20 vendors serving the CMH&A and CSS subsectors. Through the LHIN's sector engagement, HSPs have expressed some dissatisfaction with their current client management systems and concerns about vendor costs when reporting requirements change (e.g. addition of OCAN or RAI-CHA). In order to address these issues, a project team is currently in place to work with community sector HSPs to identify existing challenges with the collection of client data and access to information for decision support and engage with sectors to gather requirements and specifications for client management systems that will address these concerns.

Goal(s):

- *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 Health Links.

Consistency with Government Priorities:

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.					
"We will deliver the following"	**2014/15**		**2015/16**		**2016/17**	
	Status	**%**	**Status**	**%**	**Status**	**%**
Clinical Integrations The TC LHIN continues to work with the HSPs to improve clinical integration across sites. TCLHIN will complete plans for Academic Cardiac Services, Vision Services and Orthopaedics.	On going		On going		On going	
Exercise Falls Prevention – expansion Increasing access to community based exercise classes and falls prevention programs for seniors, optimizing the MOH new investments in 2013/14. TC LHIN is working with 8 community HSP's and other community partners to identify additional sites and deliver these programs for seniors across TC LHIN in a wide variety of locations, languages and program levels to meet the needs of seniors.	On going					
Standardized Discharge Summary - Ensure TC LHIN hospitals implement standardized discharge summary more fully throughout their hospitals	On going	20 %	On going	50%	On going	80%
Community Business Intelligence - Broaden the set of data captured in the community business intelligence system to get a full picture of the patient journey across community sectors	On going	25 %	On going	50%	On going	80%

RMR Palliative - Automate referrals for palliative beds in TC LHIN through Resource Matching and Referral	In progress	75 %	Completed	25%		
Languages Services Toronto - continue to expand use of language service Toronto in the community	Ongoing					

How will we measure success?

- Increased percentage of Toronto health service providers adhering to best practice care pathways (Stroke; hip and knee replacement)
- Increased areas in TC LHIN hospitals using standardized discharge summary
- Increased number of HSPs involved in joint procurement and purchasing through Community Shared Services Coordinator (CSSC)
- Increased volume of service provided through Language Services Toronto (in minutes)

Integrated Health Service Priorities

Sustain our gains

Community Engagement Three Year Plan

The TC LHIN recognizes that every community within our borders has unique characteristics and needs and we make our best effort to consider all voices when we undertake community engagement. The Toronto Central LHIN engages with six types of groups: public; health service providers; health professionals/workers; strategic partners; government and elected officials and interest groups; and priority communities.

Our approach includes engagement with local health service providers, training community navigators and combining the community with the health service provider engagement to develop system planning and recommendations. Local decision-making is the model that the LHINs are built on, and one that values the input of community members, health care professionals, and stakeholders to inform our planning and decision-making processes.

We believe that the most important people in the health care system are patients. In light of the fact that the LHIN is the sole planning entity with the legislated mandate to engage the public, patients and their families regarding the design and integration of services, the LHIN will be developing a multi-pronged approach to community engagement. The plan will be designed and executed over three years, with the goal of increasing the level of skill in community engagement for both LHIN staff and HSPs.

The plan will ensure that community engagement is undertaken for a range of purposes including direct outreach to marginalized communities, beginning with three and growing to five, conduct broad engagements regarding the priorities of the LHIN, and more targeted engagements to support the development of a program specific design.

Planning for Marginalized Communities

The TC LHIN recognizes that some populations are excluded from traditional opportunities to participate in planning and service design because of poverty, socio economic factors and cultural barriers. To ensure that the LHIN is able to understand and respond to the needs of these populations, a new process, which has been modeled after a successful pilot in St. James Town will be scaled to other communities that face similar barriers to participation in the planning process.

TC LHIN is a geography comprised of 72 neighbourhoods, several of which are polarized in terms of their socio-demographic characteristics. TC LHIN uses a combination of data and engagement to identify communities of need. From an information perspective, TC LHIN has been a partner in the Urban HEART project that will assist in its identification of areas of neighbourhoods of need moving forward. Based on a World Health Organization framework designed to help city leaders of developing cities and their communities resolve health inequities, Urban HEART Toronto is a unique framework designed to bring organizations from diverse sectors together to solve health and social equity problems in an urban context of a developed city. Urban HEART combines research evidence, partners' organizational data and community knowledge to assess urban equity in relation to five policy domains:

1. Economic Opportunity
2. Social Development
3. Physical Environment
4. Participation in Decision-Making
5. Healthy Lives

It is a partnership of the City of Toronto, Centre for Research in Inner City Health, TC LHIN, Toronto District School Board, United Way of Greater Toronto and other partners, and will help inform TC LHIN's focus on communities where inequities are prevalent.

Over the next three years, the TC LHIN will select five neighborhoods that will participate in a focused set of activities that include community engagement in the identification of conditions that pose a significant barrier to the access to services. The engagement will focus on the development of new models of care, designed to respond to the needs that are identified. These solutions will then become part of the integrated plan of the Health Link serving those communities to ensure that information collected during the engagement phase inform service delivery.

1. **St. James Town** is a high-density neighbourhood with a vulnerable population that often faces barriers to health care. After an apartment fire displaced many residents in 2010, health disparities and services gaps were uncovered that impact the community's access to care.

To address this, the TC LHIN in collaboration with partner organizations, spearheaded an initiative called Health Access St. James Town. Community leaders and health service providers were brought together determine what services the St. James Town community needed.

Two services that came out of the discussions were; a mobile dental clinic and a seniors mental health day program. The Mobile Dental Clinic has served over 120 clients – people who may other may not have had the opportunity to visit a dentist. To support seniors' quality of life and to encourage the aging at home philosophy, the St. James Town Mental Health Day program was launched. Since its launch in 2012, the program has welcomed more than 60 unique individuals.

Today, Health Access St. James Town continues to create linkages in the community. TC LHIN will work with local health care providers to ensure the needs of the community are being met. As well, the Mid-East Toronto Health Link will engage physicians to enhance access to primary care, producing better health outcomes for all.

2. **Mount Dennis** is one of Toronto's priority neighbourhoods with high unemployment and a higher than average number of single-parent families. TC LHIN partnered with Patient Destiny (a patient-led advocacy group that encourages patients to become better informed partners in their health care) an effort to better understand the challenges that many in Mount Dennis face in accessing and using health services. TC LHIN spoke with and heard from residents living in the Mount Dennis community and these insights have formed the basis of an important report that will be used by the Toronto Central LHIN as we continue to build solutions with health service providers in an effort to achieve a high achieving local health system for everyone in the community.

3. **Flemingdon/Thorncliffe** is home to many young immigrant families who predominantly live in high rise apartments and tend to go east for the majority of their health care needs. This area also has a high rate of chronic disease, particularly diabetes and high blood pressure. The LHIN's review determined that access to primary care is the key issue for this neighbourhood. Given the population of this area (young, immigrant families) and the high incidence of diabetes and high blood pressure, it is believed that they would benefit from more organized access to primary care services. The LHIN will lead a detailed analysis of health care service needs and opportunities in 2014/15 in collaboration with local stakeholders with a goal of development of a short term and long-term plan to address key issues, pressures and gaps.

Improved Collaboration through eHealth Technology

A number of eHealth and Information Management projects are underway across organizations in TC LHIN. These initiatives are meant to support and enable key health system priorities. They support and underpin the Toronto Central LHIN Strategic Plan and will also help to facilitate the outcomes targeted through Health Links.

The benefit of electronic solutions is that they provide clinicians with the ability to securely share information within, and across, health sectors. This will enable providers to have a more comprehensive

view of the patients' needs and facilitate improved patient transitions across the continuum of care. Furthermore, having access to data about a patients care journey enables organizations and the LHIN to develop informed plans to improve service delivery.

ConnectingGTA: The TC LHIN continues to provide its support to the ConnectingGTA program, which has made significant progress towards delivering a regional electronic health record. This solution is a rich collection of relevant patient information such as hospital reports, CCAC reports, lab information and other clinical information from 11 hospitals and 5 CCACs across Central Ontario. It will enable providers to have a comprehensive profile of a patient's health care needs in support of improved quality of care.

Hospital Report Manage (HRM): The TC LHIN is actively promoting the implementation of HRM with our providers. This initiative will automatically push hospital reports directly into the Electronic Medical Records (EMRs) of primary care providers, significantly improving their ability to provide timely follow-up, safe and quality care to their patients. A TC LHIN hospital was the first site to implement the provincial-grade HRM solution and the LHIN will continue to encourage the expansion to remaining organizations in the LHIN.

Resource Matching and Referral (RM&R): A critical system resource within Toronto is the Resource Matching and Referral solution. The LHIN and its providers rely on RM&R to facilitate referrals across organizations and use its rich data to understand barriers for patient transitions. The LHIN has already begun to incorporate the provincial referral standards into this solution and is looking to expand the use of RM&R to support its priorities by beginning the process of automating referrals for mental health and palliative care in the coming year.

Goal(s):

- *TC LHIN remains in the top quartile for wait times (ER, surgical and diagnostic) and ALC reduction.*
- *Reduced percentage of long-stay ALC patients.*
- *Number of target patients benefiting from telehomecare and telehealth services.*

Consistency with Government Priorities:

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.					
"We will deliver the following"	**2014/15**		**2015/16**		**2016/17**	
	Status	**%**	**Status**	**%**	**Status**	**%**
Community Engagement/Planning for Marginalized communities	In progress		Ongoing			
Increase the collection of socio-demographic equity data elements in hospitals and throughout CHC sector	In progress	50%	Completed	50%		
Reduce percentage of LS ALC clients through proactive transitions and planning for the right place of care from home. Activities in 13/14 will include: • Maintain and advance TC CCAC LS ALC Intensive Case Management (ICM) program across all acute and rehab hospitals. • In collaboration with hospital staff, TC CCAC LS ALC ICM will increase focus on clients who are at high-risk of long-stay ALC designation to prevent ALC designation and begin discharge planning earlier.	Completed	100%				

How will we measure success?

- Maintain percentage of ALC days in TC LHIN hospitals
- Increased collection of standardized equity data among health service providers (% of patients for whom data is collected; # of HSPs)

What are the risks / barriers to successful implementation?

The availability of socio-demographic data is critical as a building block for developing equitable programs and services and ensuring equitable access to care. Despite its importance, the collection of this data requires significant change management and for some hospitals, changes to their IT systems that compete with other priorities.

LHIN Operations Spending Plan

Operations Spending Plan (FORM 1C)				Toronto Central
LHIN Operations ($)	**2013/14 Actual**	**2014/15 Plan**	**2015/16 Outlook**	**2016/17 Outlook**
Operating Funding (excluding initiatives)	**5,533,061**	**5,555,121**	**5,598,113**	**5,598,113**
Initiatives Funding (e.g. E-Health, A@H, ED, Wait Time, etc.)	**5,068,111**	**4,020,234**	**3,962,865**	**3,755,616**
Salaries and Wages	3,192,443	3,469,804	3,469,804	3,469,804
Employee Benefits				
HOOPP	290,991	423,448	423,448	423,448
Other Benefits	395,376	451,295	451,295	451,295
Total Employee Benefits	***686,367***	***874,743***	***874,743***	***874,743***
Transportation and Communication				
Staff Travel	14,953	17,855	17,855	17,855
Governance Travel	415	720	720	720
Communications	102,326	43,703	46,384	46,384
Others	13,045	816	816	816
Total Transportation and Communication	***130,740***	***63,094***	***65,775***	***65,775***
Services				
Accommodation	279,444	454,197	489,587	489,587
Advertising	-			
Community Engagement	1,776	5,839	5,839	5,839
Consulting Fees	227,072	39,654	39,654	39,654
Equipment Rentals	1,987	4,608	4,608	4,608
Insurance	2,932	6,084	6,084	6,084
LSSO Shared Costs	371,494	245,218	245,218	245,218
Collaborative Expenses	47,500	28,643	28,643	28,643
Other Meeting Expenses	3,264	11,581	11,826	11,826
Board Chair's Per Diem expenses	21,000	36,408	36,408	36,408
Other Board Members' Per Diem expenses	35,575	61,677	61,677	61,677
Other Governance Costs	2,993	1,195	5,871	5,871
Printing and Traslation	22,946	75,431	75,431	75,431
Staff Development & others	61,601	71,486	71,486	71,486
Other Services	-	-	-	-
Total Services	***1,079,585***	***1,042,021***	***1,082,332***	***1,082,332***
Supplies and Equipment				
IT Equipment	40,172	47,336	47,336	47,336
Office Supplies & Purchased Equipment	50,183	58,122	58,123	58,123
Other S & E	-	-	-	-
Total Supplies and Equipment	***90,354***	***105,458***	***105,459***	***105,459***
Capital Expenditures	353,572	-	-	-
LHIN Operations: Total Planned Expense	**5,533,061**	**5,555,121**	**5,598,113**	**5,598,113**
Annual Funding Target				
Operating Surplus (Shortfall)	**0**	**0**	**0**	**0**
Amortization of Tangible Capital Assets	333,116	222,478	222,478	222,478
Initiatives Spending				
Aboriginal Community Engagement	20,000	20,000	20,000	20,000
French Language Service	106,000	106,000	108,136	108,136
French Planning Entities	568,713	568,713	568,713	568,713
Primary Care LHIN Lead	75,000	75,000	75,000	75,000
Critical Care Lead	75,000	75,000	75,000	75,000
ER/ALC Lead	100,000	100,000	100,000	100,000
ED Lead	75,000	75,000	75,000	75,000
LHIN Shared Services Office (LSSO)	740,000	-	-	-
Wait Time ALC RM&R Support	354,000	206,722	206,722	206,722
Diabetes Regional Coordination Group (DRCC) - One Time	1,267,521	1,129,301	1,129,301	1,129,301
Diabetes Regional Coordination Group (DRCC) - Base	-	-	-	-
Physiotherapy Reform	27,341	-	-	-
LHINC	670,000	640,000	640,000	640,000
E-Health	580,000	580,000	510,000	510,000
Provincial End-of-Life Care Netw ork (LHINC)	18,453	30,000	-	-
Diabetes Early Detection	50,000	-	-	-
Pam Am Games	69,083	414,498	207,249	-
Emergency planning	-	-	-	-
RMR Cluster 2	272,000	-	247,744	247,744
LHIN Operations and Initiatives- Total Actual/Planned Expense	**5,068,111**	**4,020,234**	**3,962,865**	**3,755,616**

LHIN Staffing Plan (Full-Time Equivalents) Operations

Position Title	2013/14 Forecast	2014/15 Plan	2015/16 Outlook	2016/17 Outlook
LHIN Operations				
CEO	1	1	1	1
Senior Director	5	5	5	5
Executive Assistant	2	2	2	2
Administrative Assistant	4	4	4	4
Receptionist	1	1	1	1
Community Eng and Communications Consultant	1	1	1	1
Planner	-	-	-	-
Sr Perf/Cont/Alloc Consultant	5	5	5	5
Business Manager	1	1	1	1
Financial Coordinator	1	1	1	1
Financial Analyst	4	4	4	4
Program Dev Consultant	1	1	1	1
Sr Planner	2	2	2	2
Sr. Integration Consultant	1	1	1	1
Perf Measurement Analyst	2	2	2	2
Sr. Community Engagement Consultant	1	1	1	1
Communications Coordinator	2	2	2	2
Health Design Consultant	1	1	1	1
Accounting Manager	1	1	1	1
Consultant	3	3	3	3
Sr. Consultant	5	5	5	5
Coorporate Coordinator	1	1	1	1
French Language Services Coordinator	1	1	1	1
Analyst	3	3	3	3
Senior Lead	1	1	1	1
Project Manager	1	1	1	1
GRAND TOTAL	**51**	**51**	**51**	**51**

Communications Plan

Business Objectives:

The ABP is a document essential to the work of the Toronto Central LHIN. It guides the work of the LHIN in three ways:
1) Builds on past successes and outlines the action plans and resources to be allocated in the upcoming year as a way to reach the goals and objectives of the IHSP 2010-13
2) Provides a framework the LHIN can use to communicate the impacts of regional decision-making on health care delivery
3) Provides an opportunity for the LHIN to fine-tune its strategies during the coming year.

Guided by Ontario's vision "*to make Ontario the healthiest place to grow up and grow old*", the ABP acts as a guide for how TC LHIN will develop a regional system of integrated health care across the care continuum, from primary care and public health through to community, acute and long-term care by:

- Improving access to a better integrated Primary Health Care System
- Supporting Primary Health Care with better management of chronic conditions
- Supporting the development of a strong, relevant, hospital system
- Implementing the Clinical Services Roadmap
- Creating and implementing capacity plans to further high-quality care for specific specialized services such as surgery
- Strengthening Community Support & Community Mental Health and Addictions Service
- Improving access to quality Mental Health and Addictions Services
- Enhancing an effective and comprehensive information management system

Communications Objectives:

- Raise awareness with the public and among health service providers of:
    - The Toronto Central LHIN's role to improve access to quality health services
    - The Toronto Central LHIN's role as a leader in transforming the health care system ex: the LHIN is working closely with their Health Link leads to improve care for complex patients by bridging gaps in the system.
    - The role of the LHIN in planning for the health needs of the community
    - The role of the LHIN in ensuring services are coordinated and aligned to the needs of patients.
    - The role of the LHIN and health service providers to identify opportunities to integrate the services of the local health system and provide appropriate, coordinated, effective and efficient services based on funding available, and to track performance against accountability agreements.
- To inform the public of the many services available in their communities
- To provide timely communications to both the public and health services providers in the Toronto Central LHIN
- To ensure that information is available to the many multicultural populations in the Toronto Central LHIN, in a culturally sensitive and appropriate manner.

Context:

Ontario's Action Plan for Health Care, announced by the Minister in January 2012, which is consistent with the principles of the Excellent Care for All Act (2010), puts LHINs at the centre of health system transformation. As such, LHINs have a critical role to play in key provincial initiatives such as Health System Funding Reform, Health Links, Seniors' Strategy and the expansion of Quality Improvement Plans into the primary and community care sectors.

The TC LHIN's plan identifies actions that need to be taken to improve our uniquely urban health care system and respond to the changing needs of the people served in our LHIN. If we do not change the health care spending trend of the past decade, health care will crowd out all other programs, such as housing and education, which have a decisive influence on the health, well-being and prosperity of our communities. Recognizing the breadth of the factors that contribute to health outcomes, a considerable amount of LHIN resources have been dedicated to building the foundation upon which a newly transformed health care system will rely. This work involves an investment plan for the transformation of the community sector, a significant shift towards population health planning, and the development of a system-wide focus on quality and equity.

The Toronto Central LHIN's IHSP and the initiatives laid out in this Annual Business Plan are strategically aligned with government direction and priorities and recognize the joint accountability of the Ministry and LHINs to serve the public interest and effectively oversee the use of public funds.

Target Audiences:

Ministry of Health and Long-Term Care

Internal to the Toronto Central LHIN:

- *Board of Directors*
- *Senior Management Team*
- *Staff*
- *Physician leads*
- *Advisory Groups*
  - *Aboriginal Health*
  - *French Language*
  - *Mental Health and Addictions*
  - *Children and Youth*
  - *Health Professional Advisory Committee*
  - *Strategic Advisory Council*

Toronto Central HSPs:

- *Mental Health and Addictions Agencies*
- *Toronto Central CCAC*
- *Community Health Centres*
- *Community Support Services*
- *Hospitals*
- *Long Term Care Homes*

External Stakeholders:

- *Public (all residents of the TC LHIN and those who access services within its boundaries)*
- *Media*
- *MPPs*
- *Public Health Units*
- *Other funders*
- *Other community agencies*

Key Messages:

Ontario is shifting the focus of its health care system to revolve around the person. We have a plan to ensure Ontarians have access to high quality care and a sustainable health system for years to come. By organizing our system differently and focusing on medical evidence, we will provide Ontarians with better care and better value for tax dollars.

Through these changes, we expect to see:

- *Reduced wait times and faster access to family doctors*
- *Fewer unnecessary visits to the emergency room and re-admissions to hospital*
- *Patients receiving care at home or in the community instead of in a hospital*

How are we transforming the health care system?

- *Partnering with the sector and enabling them to play an active role in how the system will change.*
- *Strengthening community agencies to support providers and encourage integration around the patient's needs.*
- *Health care funding will be determined based on the best evidence and will follow the patient.*

What can we expect from these changes to the healthcare system?

- *A system built for patients by the health care providers and leaders closest to them.*
- *A health care system that integrates providers around patients to deliver better outcomes.*

The Toronto Central LHIN is working behind these scenes to better organize and coordinate services for patients, clients and families.

- The TC LHIN does play a central role in ensuring important health care improvements underway.
- The TC LHIN is focusing on the *big* problems that concern the public and improving the health care system, overall.
- The TC LHIN is focused on ensuring the people we serve are well supported and have timely access to care – regardless of income, age, race, ethnicity or sexual orientation

Now and over the next few years the Toronto Central LHIN is working to:

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

Strategic Approach:

Moving forward our communications 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 City of Toronto. TC LHIN will undertake different communications strategies in support of the ABP priorities and actions based on the specific objectives and audiences/stakeholders. Overall our communications will:

- Continue to develop and leverage opportunities to build the reputation and establish credibility of the Toronto Central LHIN by informing health care providers and residents of Toronto about programs and initiatives that will improve care for all.

- Inform and build awareness among health service providers of shared accountability of the LHIN and health service providers in transforming the health system

- Ensure stakeholders understand the role of respective organizations and support integration opportunities that improve patient care

- Track and report performance against accountability agreements.

Additionally, Toronto Central LHIN's communications initiatives will support the Ontario government's Action Plan for Health Care. Specifically, LHINs have a responsibility in important provincial initiatives such as Health System Funding Reform, Health Links and the Seniors Strategy and these priorities will be featured in our ongoing communications efforts.

Tactics:

Our LHIN has a comprehensive range of communication vehicles that it leverages to highlight progress and collective successes in achieving the IHSP priorities and over the last two years the Toronto Central LHIN has met and consulted over 2000 providers and patients. The TC LHIN makes use of a toolbox of quality communication and community engagement tools and vehicles, including

- *Annual Report*
- *Report to the Community*
- *CEO Reports to the Board*
- *Proactive and responsive news releases*
- *eNewsletters*
- *Stakeholder eblasts,*

- *Quarterly sector table and committee meeting,*
- *Community engagement reports*
- *Social media,*
- *Program based brochures,*
- *Senior leadership presentations and speaking engagements*
- *Regular website updates*
- *Organizing knowledge-building and information-sharing events such as quality forums, think tanks and other community meetings*
- *Building and maintaining working relationships with provincial and local government representatives*
- *Participating in partnerships, such as the provincial LHIN communications group, and forging links with communications leads at HSPs.*

Evaluation

A formal and comprehensive evaluation of the TC LHIN's communications efforts will be conducted in-house. The evaluation would include the following measures:

- Tracking positive editorial coverage/limited negative editorial coverage - This information will be collected and evaluated within a context of transparent disclosure.
- Website traffic - Using analytics, pages and specific postings are tracked.
- Identifying and tracking critical communication success factors will enable the Toronto Central LHIN to more effectively identify whether communication activities have been successful.
    - Visible senior leadership engagement and support of the ABP initiatives and related communications.
    - Senior leadership and LHIN-wide committees take visible, active roles in supporting communications and change with their teams as tracked in shared communication and community engagement plans.
- Feedback mechanisms and ongoing assessment are in place to monitor the effectiveness of communication vehicles and messages, and the TC LHIN has the ability to make quick modifications based on shifts and lessons learned as activities are carried out.

Community Engagement

LHIN role in community engagement

As set out in Section 16 of the *Local Health System Integration Act 2006,* Ontario's Local Health Integration Networks (LHINs) are required to "…engage the community of diverse persons and entities involved with the local health system about that system on an ongoing basis, including about the integrated health service plan and while setting priorities. 2006, c. 4, s. 16 (1)". Ministry of Health and Long Term Care (the Ministry)-LHIN Accountability Agreement, as well as government directives, reinforce the expectation that community engagement is a fundamental part of the way local health care services are planned and priorities are set and implemented in the LHIN.

"Community" as defined by LHSIA:

- Patients and other individuals in the geographic area of the network;

• Health Service Providers (HSPs) and any other person or entity that provides services in or for the local health system; and
• employees involved in the local health system.

There are special obligations for the LHIN to engage Aboriginal and French-speaking communities and there are particular obligations related to integration, whether voluntary, facilitated, funded or directed. LHSIA includes a prescribed period for public submissions regarding LHIN integration decisions and HSPs are required to undertake community engagement as part of these activities.

Toronto Central LHIN Approach to Community Engagement

Effective community engagement was an important driver behind the implementation of Toronto Central LHIN's 2012-2014 Integrated Health Service Plan (IHSP-3). The Toronto Central LHIN has a diverse population and effective engagement requires a creative approach that not only promotes equity and reflects and respects our community's diversity, but also builds on and leverages the strengths of the leaders of our health service provider organizations and our community. This refreshed community engagement strategy sought to expand and deepen the LHIN's reach into diverse health care providers, patient/client and resident communities, including Aboriginal, Francophone, ethno-cultural neighbourhoods, and marginalized groups.

Community Engagement Three Year Plan

The TC LHIN recognizes that every community within our borders has unique characteristics and needs and we make our best effort to consider all voices when we undertake community engagement. The Toronto Central LHIN engages with six types of groups: public; health service providers; health professionals/workers; strategic partners; government, elected officials and interest groups; and priority communities.

Local decision making is the model that the LHINs are built on, and one that values the input of community members, health care professionals, and stakeholders to inform our planning and decision-making processes. Our approach includes engagement with local health service providers, training community navigators and engaging both the community and health service provider together, in order to foster joint planning that results in more coordinated services.

We believe that the most important people in the health care system are patients. In light of the fact that the LHIN is the sole planning entity with the legislated mandate to engage the public, patients and their families regarding the design and integration of services, the LHIN will be developing a multi-pronged approach to community engagement. The plan will be designed and executed over three years, with the goal of increasing the level of skill in community engagement for both LHIN staff and HSP providers. The plan will ensure that community engagement is undertaken for a range of purposes including direct outreach to marginalized communities, beginning with three and growing to five, conduct broad engagements regarding the priorities of the LHIN and more targeted engagements to support the development of a program specific design.

Overtime the LHIN's community engagement strategy will focus on five priority neighbourhoods to expand the lens of understanding to those users not engaged with the system: St. James Town, Mt. Denis, Crescent Town, Thorncliffe and Flemingdon. In addition, the LHIN will continue to support planning and engagement activities in other priority areas such as the Aboriginal and Francophone communities, chronic disease and Health Links to continue to improve the patient experience across and through the health system.

The model of participation has been adapted from the International Association for Public Participation (IAP2) framework. This framework is values-based, decision-oriented and goal-driven and will guide the level of participation to be applied to Toronto Central LHIN initiatives. The level of community engagement spans a spectrum with an increasing level of community impact that defines the community's role and the formulation of the engagement goal that drives the engagement process.

The following principles will guide community engagement activities.

Inclusive
We will engage with the full range of healthcare consumers, providers, and communities that have a stake in, or will be impacted by, our plans. We will implement specific outreach activities to engage hard-to-reach and marginalized populations.

Timely
We will engage with stakeholders early and often in the planning process, allowing sufficient time for meaningful dialogue, consultation and plan modifications. Our goal is to provide stakeholders with enough time to share information with their partners prior to and after engagement.

Appropriate
We will use a variety of methods of communication that reflect the needs of our stakeholders, while being efficient in the use of our resources and those of participating stakeholders. The key will be flexibility and understanding that common methods of engagement may not be effective for some stakeholders.

Accessible
We will provide clear, accessible and comprehensive information to facilitate stakeholder involvement with issues and decision making – striving to eliminate the barriers of language, culture and disabilities

Responsive
We will be respectful of, and responsive to, stakeholder input. We will modify or refine plans and actions to reflect stakeholder advice, where appropriate.

Transparent
We will engage with stakeholders openly and will be transparent about our purpose, goals, accountabilities, expectations, and constraints and how stakeholder engagement will be used in decision making.

Balanced & Equitable
We will balance the participation and influence of various stakeholder groups.

Accountable

We will monitor the effectiveness of our stakeholder engagement strategies and be accountable to our process, principles, and ultimately to the healthcare outcomes within our communities.

Community Engagement	
Community/Stakeholder	**Initiatives**
Health Service Providers	
	Standing TC LHIN advisory committees • Sector Tables (quarterly) • Strategic Advisory Council • 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: this group will be reconstituted with health professionals that are drawn from the Health Links with the goal of identifying common issues and the development of solutions that may be tested in within Health Links and scaled across the LHIN where appropriate. The Advisory Group will become an important mechanism by which the knowledge translation among health providers is achieved, with leaders from the group responsible for

	the dissemination of best and promising practices. **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. • Development of new communications tools focused on the education of patients and caregivers on the options for accessing services and self-management. • Use of residents and citizens panels designed to both inform the community of work and to gather and synthesize community response on contentious issues. • 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 sometimes 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 Hospital 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 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. • Francophone survey regarding barriers to accessing primary care services TC LHIN ensures that **Francophone engagement is included in TC LHIN priority initiative**s 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: • TC LHIN has partnered with Toronto Public Health to develop a road map for enhanced planning for Aboriginal Services. The Aboriginal Advisory Circle of Toronto Aboriginal health and other Aboriginal community agencies involved in health care delivery will be a partner in the development of this plan. • 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 working with the Centre for Research on Inner City Health (CRICH) and community engagement and development experts from provider organizations to develop collaborative engagement processes 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 regularly 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. TC LHIN **collaborates with MPPs' offices on local community engagement activities**. TC LHIN holds **annual or bi-annual meetings between all MPPs, the TC LHIN Board and CEO regarding key heath 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 with City Councillors on key issues that are of interest in their Wards or relevant 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

LHINC and LSSO Submission

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 including information technology management and business applications, procurement and vendor management, payment processing payroll services, legal, and HR advisory services to all the LHINs. TC LHIN has responsibility for operating LSSO services based on its annual work plan, which is approved by the 14 LHIN CEOs. TC LHIN also funds support for LHIN Legal Services (provided through the Ministry of the Attorney General) through LSSO.

LSSO's overall objectives are to enable efficient and effective use of resources among LHINs, enabling economies of scale and supporting adoption of best practices in back office services. Our focus for 2014-15 will be on vendor management and the integration of core business applications, ensuring LHINs maximize the value and delivery of information technology services and communication-based technology.

For pan-LHIN HR Services and Procurement Services, our focus for 2014-15 will be on aligning services to LHIN needs and priorities, ensuring their continued value and relevance to the people who use them, and improving performance reporting on service activities and deliverables.

LSSO Information Technology Services

As LHINs have evolved, so too have their support requirements. Particularly, how people receive and consume information electronically and how they collaborate and participate in business activities. While new services in each LHIN tend to grow organically once they have been proven on a smaller scale that they can work, the integration of core business applications have not kept pace with this unique needs of the LHINs.

Priorities for 2014-15 for LSSO Information Technology Services will focus on ensuring leading practices for vendor management, strengthening our partnership with key IT service providers, to ensure LHINs have a full understanding of the technology environment and a deep and insightful appreciation of Shared Service Framework.

Vendor Management

LSSO continues to apply leading practices to the IT service delivery framework. With a new partner, CompuCom, improvement to the existing Shared Services include:

- Alignment with LHINs through shared goals and objectives and working jointly to achieve high levels of service
- Proactive and predictive management of the IT environment with the goal to reduce overall incidents and improve the stability and performance of the network
- Adopt a governance model that enables desirable outcomes of IM/IT service management
- Adhere to a costing model that is predictable and demonstrates fair value
- Managing service level commitments that can be objectively measured to ensure substantial conformance with the material requirements set out in respective service contracts

SharePoint Initiative

The SharePoint initiative is a web-based Intranet platform that was developed to improve operational efficiencies through information collaboration and robust document management for individual LHINs and across the system. This project has two phases.

Phase I included the successful implementation of the SharePoint portal at 14 LHINs.

The goal of Phase II is to extend the SharePoint Web application to create an extranet-facing access point, considerations for Phase II include:

- Develop and implement integrated business solutions that will include CRM and SharePoint
- Develop document management strategies
- Develop collaboration management strategies
- Integrate existing HSP SharePoint sites so LHINs can collaborate with HSPs through extranet

SharePoint 2013 is also under review and will be discussed in the third quarter of 2014-15 under the LHIN long-term IT Strategy.

Customer Relationship Management (CRM) initiative

Customer Relationship Management was identified as an effective business tool to manage health service provider and stakeholder relationships for LHINs. CRM offers a variety of workflow improvement tools for contact management, contract management, and engagement activities.

Phase I has successfully implemented CRM in 3 LHINs. The existing CRM has one central database that is shared by participating LHINs. There is agreement and alignment on the use of the core data model currently in production. The core data model is a solid configuration to start with and to build upon.

The goal of Phase II is to extend the CRM application to all 14 LHINs, activate other features, such as: mail merge, email campaign etc., and to integrate with SharePoint for business intelligence solutions.

Integrating with GP dynamics is also under review and will be discussed in the third quarter of 2014-15, under the LHIN long-term IT Strategy.

Web Content Management initiative

Renewing the existing web content management system will assist LHINs in making websites more accessible in accordance with the AODA, 2005 and Integrated Accessibility Standards Regulation.

- Beginning January 1, 2014: If you launch a new public website or your existing site undergoes a significant refresh, the site and any of its web content published after January 1, 2012, must conform to the World Wide Web Consortium Web Content Accessibility Guidelines (WCAG) 2.0, Level A.

- Beginning January 1, 2021: All public websites and all web content on those sites published after January 1, 2012, must conform to WCAG 2.0 Level AA, other than providing captions on live videos or audio descriptions for pre-recorded videos.

Our aim is to renew LHIN website technology in 2014/15 to conform to Level AA using a system that will reduce the amount of changes the LHINs will have to make with the website down the road. It may also reduce the requests received requiring accessible formats.

LSSO Procurement Services

Centralized support for procurement activities across LHINs assists with compliance requirements and takes advantages of centralized resources through joint procurements. LSSO currently provides this support, with two distinct roles:

- *Pan-LHIN Procurements* – LSSO procures on behalf of LHINs in a number of areas (insurance, audit, payroll, benefits, IT network and support, financial IS support, website) in order to deliver cost savings through economies of scale, and reduce administrative costs through centralized vendor management.
- *Local LHIN Advisory Services* – LSSO provides templates and tools as well as advice on compliance and implementation matters to individual LHINs with a goal to support adoption of best practices and reduce administrative time for LHIN staff.

Priorities for 2014-15 for LSSO Procurement Services will focus on ensuring leading practices for vendor management, strengthening our partnership with Ministry staff to ensure LHINs are up-to-date on requirements and compliance obligations, and facilitating easy access to the knowledge and resources required by LHINs.

LSSO continues to provide ongoing procurement advisory services to individual LHINs as they move through their own procurements based on local needs.

LSSO Human Resources Services

The LHIN-Ministry MOU requires that "each LHIN shall utilize substantially similar employment policies and practices" and "each LHIN shall use or employ the same human resources services as all other LHINs either directly or indirectly through a shared service arrangement among the LHINs." While each LHIN manages the majority of their HR needs internally, LSSO HR Services provides a range of supports, including:

- Benefits administration, including vendor management, transaction support, and reporting
- Support for implementation of a Human Resources Information System, for records management
- Coordination and maintenance of core policies or policy guidelines
- Creation of common tools, templates and best practices for a full range of HR functions
- Advisory services on a range of functions, covering advice on best practices related to onboarding, recruitment, employee relations, health and safety and wellness.

HR Services priorities for 2014-15 are to identify and act on opportunities to enhance support to the LHINs, with a focus on improving access to common tools and leading practices and automating administrative processes where possible to reduce manual work. Specific areas of work will focus on improving usability and adoption of human resources information systems and development of new tools and templates based on LHIN priorities. LSSO is also continuing to work with the LHINs' benefits provider in order to improve user satisfaction.

Finance, Payroll and Corporate Services

LSSO provides the means through which LHINs can share common expenses, processes and accounting for transactions that require funds to be shared across all 14 LHINs. In doing so, LSSO provides a range of transaction processing, financial application and procurement supports on behalf of LHINs. These include support for common financial functions such as procurement of audit services and insurance services, assistance with payroll processing, and coordination of transactions for joint procurements and payments.

LSSO also acts on behalf of the 14 LHINs to fund the Legal Services Branch and facilitates administrative support for joint activities.

Risk Assessment

- The following risks have been identified and could impede LSSO's pursuit of stated objectives: Balanced budget with increase in service requirements (e.g. procurement office, project management, decision support & planning) will increase project cycle time. The mitigation may be in the form of a reduction in the spectrum of work and deferral of project until funding is secured.

- Failure of LHINs to grant additional staffing request to participate in Project committees as well as current staff not having the right skills to implement the initiatives. The mitigation may be in the form deferral of project until resources are secured

Financial Summary

Operations Spending Plan (FORM 1C)				LSSO	
LHIN Operations ($)	**2013/14 Forecast**	**2013/14 Actual**	**2014/15 Plan**	**2015/16 Outlook**	**2016/17 Outlook**
Operating Funding (excluding initiatives)	**5,663,296**	**5,714,063**	**5,663,296**	**5,719,531**	**5,786,368**
Initiatives Funding (e.g. project funding from the LHINs)	**740,000**	**740,000**	**-**	**-**	**-**
Salaries and Wages	1,421,762	1,238,820	1,634,353	1,634,353	1,634,353
Employee Benefits					
HOOPP	79,508	95,121	143,987	143,987	143,987
Other Benefits	84,909	79,386	237,296	237,296	237,296
Total Employee Benefits	***164,418***	***174,506***	***381,283***	***381,283***	***381,283***
Transportation and Communication					
Staff Travel	2,881	1,784	4,500	4,500	4,500
Governance Travel					
Communications	5,041	4,531	6,183	6,183	6,183
Others		275			
Total Transportation and Communication	***7,922***	***6,590***	***10,683***	***10,683***	***10,683***
Services					
Accommodation	176,366	168,409	178,665	194,987	197,563
Advertising					
Community Engagement					
Consulting Fees	18,071	31,630	33,946	33,946	33,946
Equipment Rentals	1,638	2,166	8,500	8,500	8,500
Insurance	2,480	2,558	2,554	2,554	2,554
LSSO Shared Costs	3,518,065	2,252,169	3,231,181	3,269,053	3,331,234
Collaborative Expenses					
Other Meeting Expenses	-	15			
Board Chair's Per Diem expenses					
Other Board Members' Per Diem expenses					
Other Governance Costs					
Printing and Traslation					
Staff Development & others	3,473	12,970	5,623	5,623	5,623
Other Services	8,788		34,694	34,694	34,694
Total Services	***3,728,881***	***2,469,918***	***3,495,164***	***3,549,358***	***3,614,114***
Supplies and Equipment					
IT Equipment	111,784	594,939	109,500	111,540	113,621
Office Supplies & Purchased Equipment	18,529	20,984	32,314	32,314	32,314
Other S & E					
Total Supplies and Equipment	***130,313***	***615,923***	***141,814***	***143,854***	***145,935***
Capital Expenditures	-	1,208,306			
LHIN Operations: Total Planned Expense	**5,453,296**	**5,714,063**	**5,663,297**	**5,719,531**	**5,786,368**
Annual Funding Target					
Operating Surplus (Shortfall)	***0***	***0***	***- 0***	***- 0***	***- 0***
Amortization of Tangible Capital Assets	415,019	468,218	400,000	400,000	400,000
Initiatives Spending					
LSSO IT Transition Project	950,000	740,000			
LHIN Operations and Initiatives- Total Actual/Planned Expense	**6,403,296**	**6,454,063**	**5,663,297**	**5,719,531**	**5,786,368**

Staffing Plan

Position Title	2013/14 Forecast	2014/15 Plan	2015/16 Outlook	2016/17 Outlook
IT Services				
Director,Technology Solutions	1	1	1	1
Administrative Assist	1	1	1	1
IS Manager	1	1	1	1
Coordinator, IT Support	1	1	1	1
Sharepoint Admin/Developer	1	1	1	1
IT Project Manager (Transition)	1			
IT Analyst & Application Specialist (Transition)/ CRM developer	1	1	1	1
Project Manager	1	1	1	1
Finance, Payroll and Corporate Services				
Finance Manager	1	1	1	1
Specialist-Payroll & Benefits	1	1	1	1
Financial Analyst	1	1	1	1
Executive Cordination				
Executive Assistant	1	1	1	1
Procurement Specialist	1	1	1	1
HR/OD Strategic Business Partn	1	1	1	1
Legal Admin	1	1	1	1
	15	**14**	**14**	**14**

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 have been factored into 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 of $0.7M for IT transition to a new vendor.
- With respect to 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 part of the project request and approval process.

LHIN Collaborative (LHINC)

Background

The LHIN Collaborative (LHINC) was established in 2009 as a provincial advisory structure to the LHINs, focused on 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 work 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 leadership, 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

LHINC 2014/15 Priorities

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 (comprising of LHIN CEOs and Board Chairs) and the LHIN CEO Council (comprising of the 14 LHIN CEOs).

In 2014/15 LHINC will continue to grow and evolve as the LHINs support implementation of the Minister's Action Plan for Health Care and other provincial strategies. Key areas of focus for 2014/15 include:

- ***Enabling Joint Work across the System to Action LHIN and Ministry Priorities*** – supporting ongoing work such as the Service Accountability Agreements (SAAs) as well as new joint tables with the Ministry including the Collaborative Care Model work group and Palliative Care Project clinical work group.
- ***Enabling Collaboration with Sector Partners*** – building on the success of the System Strategy Council and CCAC Benchmarking project, LHINC is providing support for the ongoing joint LHIN-CCAC Collaboration Table and other provincial stakeholder engagements.

- ***Timely Communications and Coordinated Response across LHINs on Pan-LHIN Issues*** – building communications capacity to support the LHINs at a provincial level, assist with issues management on pan-LHIN matters, and focus provincial joint work of the LHIN communicators.
- ***Facilitating Improvements to Improve Sharing of Leading Practices across LHINs*** – targeting opportunities for improvement in processes and information, including ongoing work to enhance SAA processes, supporting enhancements to the Health System Indicator Initiative (HSII) and developing common tools and resources for LHIN staff and leadership.
- **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, and continuing to support sector and system leadership through the System Strategy Council.

Financial Summary

Operations Spending Plan (FORM 1C)					LHINC
LHIN Operations ($)	**2012/13 Actual**	**2013/14 Forecast**	**2014/15 Plan**	**2015/16 Outlook**	**2016/17 Outlook**
Operating Funding (excluding initiatives)	**1,113,508**	**1,335,000**	**1,335,000**	**1,378,650**	**1,423,610**
Initiatives Funding (e.g. E-Health, A@H, ED, Wait Time, etc.)			**120,000**	**120,000**	**120,000**
Salaries and Wages	722,427	973,424	1,005,166	1,035,321	1,066,381
Employee Benefits					
HOOPP	56,747	62,270	69,331	71,411	73,554
Other Benefits	92,437	112,706	110,239	113,546	116,952
Total Employee Benefits	***149,184***	***174,976***	***179,570***	***184,957***	***190,506***
Transportation and Communication					
Staff Travel	1,563	750	2,833	2,917	3,005
Communications	2,123	7,000	7,891	8,128	8,372
Total Transportation and Communication	***3,686***	***7,750***	***10,724***	***11,045***	***11,377***
Services					
Accommodation	95,434	102,600	105,678	108,848	112,114
Advertising	599	-	8,370	8,621	8,879
Consulting Fees	69,888	10,500	22,150	22,815	23,499
Equipment Rentals	856	2,514	3,609	3,717	3,829
Insurance	755	827	1,570	1,617	1,665
LSSO Shared Costs	47,500	44,400	44,400	45,732	47,104
Collaborative Expenses		-	35,000	36,050	37,132
Other Meeting Expenses	2,452	1,000	5,150	5,305	5,464
Staff Development & others	3,086	2,689	12,000	12,360	12,731
Other Services	1,722	5,276	7,614	7,842	8,077
Total Services	***222,290***	***169,806***	***245,540***	***252,907***	***260,494***
Supplies and Equipment					
IT Equipment	6,442	8,200	5,000	5,150	5,305
Office Supplies & Purchased Equipment	9,478	844	9,000	9,270	9,548
Other S & E		-	-	-	-
Total Supplies and Equipment	***15,921***	***9,044***	***14,000***	***14,420***	***14,853***
Capital Expenditures		-	-	-	-
LHIN Operations: Total Planned Expense	**1,113,508**	**1,335,000**	**1,455,000**	**1,498,650**	**1,543,610**
Annual Funding Target					
Operating Surplus (Shortfall)	***0***	***-***	***- 0***	***- 0***	***- 0***
LHIN Operations and Initiatives- Total Actual/Planned Expense	**1,113,508**	**1,335,000**	**1,455,000**	**1,498,650**	**1,543,610**

LHINC Staffing Plan (Full Time Equivalents)

Position Title	2013/14 Forecast	2014/15 Plan	2015/16 Outlook	2016/17 Outlook
Senior Consultant	4	4	4	4
Project Consultant	2	2	2	2
Admin Assistant	1	1	1	1
Sr Director, LHINC	1	1	1	1
Pan LHIN Comm. Director	1	1	1	1
	9	**9**	**9**	**9**