

Toronto Central LHIN

ANNUAL BUSINESS PLAN 2017-2018

June 2017

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Mandate and Strategic Directions

The Patients First Act was passed on December 7, 2016 and the Ministers Transfer Order dated April 3rd confirmed June 7th as the date for Toronto Central CCAC transition. The Ministers Mandate Letter for 2017-18 was received on May 1st 2017.

Toronto Central Local Health Integration Network (LHIN) is one of fourteen (14) local health-planning organizations that serve Ontario. With responsibility for funding, planning, implementing and evaluating local health services, we work to meet the needs of 1.2 million residents and tens of thousands of others who travel to Toronto for care. There are 172 Health Service Providers (HSP) [1] in this LHIN including hospitals, community support services, long-term care homes, a community care access centre, community health centres and mental health and addictions agencies.

LHINs are agencies, established by the Local Health System Integration Act in 2006, which are guided by policy direction from the Government of Ontario. The Ministry of Health and Long-Term Care (the Ministry) sets out guidelines and expectations to drive improvements to local health care systems. The LHIN uses its knowledge of the surrounding landscape, providers and people to develop plans that fit the local context and meet the needs of the community.

From Windsor to Thunder Bay, from Timmins to Belleville, Ontario is incredibly diverse, and this diversity demands tailored strategies to meet the unique needs of all Ontarians. A similar approach is also required in the City of Toronto; with 140 neighbourhoods and disparate communities of people across Toronto, this city is home to many marginalized and underserved populations each requiring a tailored approach to improving health care in a safe and culturally-appropriate way. At the core of Toronto Central LHIN's (the LHIN) approach to planning is an in-depth understanding of the communities that we serve, and we use this knowledge strategically to drive the design and delivery of the services provided to the citizens of Toronto.

The Toronto Central LHIN occupies a unique position within the infrastructure of the health care system in Ontario. While Toronto Central LHIN's physical boundaries encompass the smallest geographic footprint of the fourteen LHINs, the impact of the highly concentrated number of health service providers (HSP) contained therein resonates across the entirety of the province. Toronto Central LHIN receives roughly 19% of the overall financial transfer to the LHINs, mostly attributed to the fact that these providers serve as a regional and provincial resource. A considerable proportion of care delivered in the Toronto Central LHIN is to residents from outside of the catchment area (ranging from approximately 36.9% for unscheduled ED visits to 58.3% for Rehab in FY 2013/14) [3].

As a result of this, the LHIN recognizes the critical role that our Academic Health Science Centres play in ensuring ongoing excellence in highly specialized services to Ontario, while at the same time the system remains responsive to the needs of this rapidly growing community.

We also realize that the health status of Torontonians is largely defined by the social determinants of health, which are factors such as race, sexual identity, income and housing that are key contributors to an individual's overall health status. Because of this, our work cannot achieve our goals alone; creating connections and convening strategic partnerships has allowed Toronto Central LHIN to improve care in local communities and neighbourhoods.

As Toronto Central LHIN has evolved, it has refined its approach to planning locally with the understanding that the health care system should reflect the needs of the people who it is serving in its priorities and its design. This principle is a key underpinning of the Toronto Central LHIN 2015-18 Strategic Plan. The passage of the *Patients' First Act*, on December 7th, 2016 will change the experience of the patient/client/resident/caregiver by deepening the integration between primary care/community care and the health care system, improving access, coordination of care and their ability to navigate the health care system.

The immediate impact of the new legislation is the proposed timetable for integration of Toronto Central LHIN and Toronto Central CCAC (planned for June 7, 2017 through Minister's Order). This transition is a major focal point for the organizations' operational activities in this fiscal year. Continuity of care and business are core operational goals for Toronto Central LHIN throughout this transition year. These efforts will be carried out in parallel with the organization's ongoing implementation of the Strategic Plan.

Toronto Central LHIN is now in the third, and final year of the 2015-18 Strategic Plan, and the LHIN continues to be focused on working with health and non-health partners, residents, patients, family members, clients and caregivers to build a local health care system that is coordinated, easy to navigate and provides timely and equitable access to care.

Given these significant and upcoming changes, the LHIN moved to update our Strategic Plan, signalling a collaboration between our organizations on planning. The revised plan leverages our shared goal to improve the integration of care both at the system level and in service delivery. This year the Annual Business Plan reflects our organization in transition. Since the integration is not yet complete, the plan does not show a full set of activities, but provides a snapshot of integrated activities.

Toronto Central LHIN

Strategic Plan 2015-2018: Year 3 Update



CCAC Strategic Plan



Toronto Central LHIN

Our Strategic Plan 2015-2018



Toronto Central LHIN and Toronto Central CCAC have undertaken the refinement of the strategic plan for 2017/18 in order to reflect the two organizations coming together. The resulting integrated strategic plan reflects CCAC strategic priorities, goals and values. Over the coming year, the new LHIN will work to develop a new three-year strategic plan that is reflective of our new mandate.

A key change is the addition of our One Team, One Plan approach, which represents a vision of a fully integrated health care system and a fully integrated LHIN. This approach is consistent with the long history of close collaboration between the LHIN and the CCAC. This collaboration has led to many joint priorities and initiatives.

The renewed organization will have a mandate for planning, funding and integrating services as well as the coordination and delivery of home care services.

Overview of Current and Forthcoming Programs

New LHIN Organization: In the coming year, the Toronto Central LHIN's role will be expanding from planning, funding, and integrating to include the delivery of home and community care. In-line with the Patients First Act (2016), the objectives of the LHIN will include the following:

Achieving Patients First in Toronto Central LHIN (March 2017)

Objective	Action	Status
Effective Integration of Services and Greater Equity	1. Identify LHIN sub-regions as the focal point for integrated service planning and delivery.	1. LHIN sub-regions established and started local collaboration with providers from all sectors
Timely Access to, and Better Integration of, Primary Care	2. Primary care planning and performance improvement Primary Care Clinical Leads	2. Primary care strategy in place, Primary Care Clinical Leads working within sub-regions, Primary Care Community Committees active
More Consistent and Accessible Home & Community Care	3. Transfer service management and delivery of home to the LHINs.	3. Patients First Act passed, transition planning to move Home and Community Care under management of LHIN's
Stronger Links to Population & Public Health	4. Linkages between LHINs and boards of health with population health approach	4. Engagement and partnership with Toronto Public Health, City of Toronto and launch of Citizens' Panel
Inclusion of Indigenous Voices in Health Care Planning	5. Inclusive of Indigenous and Francophone needs through a stronger role in system planning	5. Toronto Indigenous Health Strategy in place, model identified for Indigenous Health care

Planning for Change: In order to effectively plan for the integration of Toronto Central CCAC into the LHIN, a joint transition team with senior level representatives from both the LHIN and CCAC was established. By building on a long standing history of partnership between both organizations, it was agreed that a principle of transition would be to create a vision for the new organization that builds on the successes and strengths of both the Toronto Central LHIN and Toronto Central CCAC, where we collaborate together as one entity based on shared mission and goals.

Change readiness planning has been an important component of this work to ensure that both organizations can successfully come together as one team, with a focus on supporting our staff from front-line to leadership through transition.

Subject to Minister's Order, the new integrated LHIN will continue to deliver high quality and integrated home and community care to the people of, and those seeking care in, Toronto Central LHIN within an integrated health care system. Post-transition, the new organization will

begin to focus on transformation by engaging the clients, residents, caregivers, partners and providers across the Toronto Central LHIN to build a new integrated Strategic Plan. Transition Day is planned for June 7, 2017.

Primary Care: The Toronto Central LHIN launched a consultation with a broad range of physicians and partners in early 2016 to inform the development of an integrated Primary Care Strategy. This strategy identified five (5) priorities: Attachment, Access and Continuity; Access to Interprofessional Teams; Discharge Planning; Access to Specialists; and Secure Communications. Primary Care Clinical Leads (PCCLs) have been recruited into leadership positions in our five sub-regions within the Toronto Central LHIN and their focus is to lead planning and engagement at the system and local level focused on these five priorities in order to improve patient access, service integration and system efficiency.

Integrated Home and Community Care: A move toward integrated community care requires collaboration across many providers, and must be guided by a shared vision for health service delivery that responds to local needs. Toronto Central LHIN has launched an integrated community care initiative as part of our 2015-18 Strategic Plan and in partnership with the work underway to strengthen primary care.

Strategic Partnerships: Toronto Central LHIN, GTA LHINs and City of Toronto have established a joint leadership table to identify and advance mutual strategies to improve the health and well-being of Torontonians. In addition, Toronto Central LHIN has established a formal partnership with Toronto Public Health to identify and collaborate on shared priorities.

Toronto Central LHIN and City of Toronto have agreed to develop a Health Accord as a framework for partnership and joint planning focused on improving health outcomes for those who live, or seek services in Toronto. By developing an accord between the City and the LHIN, the local health system can leverage the many programs and services that the City supports including paramedics, municipal long-term care, public health, and social services.

Population Health and Equity Strategy: The Toronto Central LHIN is taking a population health approach to planning at the local level. This means that the LHIN is using data, informed by community consultation to understand the greatest gaps in health, and to target efforts and investment. The LHIN recognizes that many populations require the combined effort of health and social sectors to develop joined prevention, early intervention and targeted interventions in order to significantly improve their health outcomes. For this reason, the LHIN has developed an extensive partnership table that will provide oversight three key streams of work:

1. Generating tools that will help us understand and stratify the population into smaller groups based on need and risk.
2. Seeking to develop health equity solutions for particular populations whose health outcomes are significantly poorer than the broader group.
3. Providing tools to clinicians to help them more effectively serve particular groups of patients and clients.

There are four core components to the Population Health and Equity Strategy that include: Health-Based Assessment; Health Equity; Practice-Based Population Health; and Strengthening our Partnership with Toronto Public Health.

Local Collaboratives: The Toronto Central LHIN has established five sub-regions (Local Collaboratives) to serve as the focal point for population based planning, service alignment and integration, and performance improvement. Several sessions of Local Collaborative meetings have brought together over 280 Health Service Providers, partners and residents throughout the year to develop a deeper understanding of the local neighbourhoods and populations within each sub-region. A profile of each sub-region has been included below (please note that the neighbourhoods that are split between two sub-regions are represented in both sub-regions).

EAST TORONTO

269,756 residents
21 neighbourhoods
6255 people/sq km

*Relatively young, ethnically diverse immigrant population,
low socio-economic status in some areas.* Data Source [4]

East Toronto sub-region overview:

- Highest proportion (22.9%) of children and youth (ages 0-19 years) in 2011 among the Sub-Regions and relative to Toronto Central LHIN. Thorncliffe Park has the highest proportion of children and youth (32.2%) among all the neighbourhoods in Toronto Central LHIN. [5]
- Highest proportion of recent immigrants (arrived between 2006-2011) with top three countries being: Bangladesh (17.9%), Pakistan (11.7%) and Philippines (8.9%). [6]
- Most heavily represented visible minorities relative to Toronto Central LHIN are South Asian and West Asian or Arab. [6]
- Thorncliffe Park, Victoria Village Oakridge and Flemingdon Park have particularly high levels of marginalization. [7]

Health status:

- Highest rate of total hospital births to women aged 15-49 rate: 47.7/1000 women (2012/13 to 2014/15). [8]
- Highest number of deaths (1,712) and second highest crude death rate (634.6/100,000 population) among sub-regions in 2011. [9]
- Highest prevalence rate for all chronic diseases among the Sub-Regions for 20+ years (for COPD 35+ years) (FY 2014/2015). [10]



Primary care and other health service providers:

- 230 primary care physicians, with 16% in Community Health Centres and Family Health Teams. Some areas with very few primary care physicians. [11,12]
- Neighbourhoods with the lowest levels of continuity of primary care include Thorncliffe Park (27.8%), Flemingdon Park (24.3%) and Taylor-Massey (23.3%). [13]
- Michael Garron Hospital is the main hospital in the area. 10 Community Support Services, 5 Community Mental Health and Addictions agencies and 8 Long-term Care Homes. [1]

Health service utilization:

- 27% (25,430) of a total 94,279 Emergency Department visits were of low urgency 2015/2016. [14]
- 13.5% of the total number of hospital inpatient days were designated as Alternate Level of Care. [15]

MID-EAST TORONTO

143,392 residents
9 neighbourhoods
6557 people/sq km

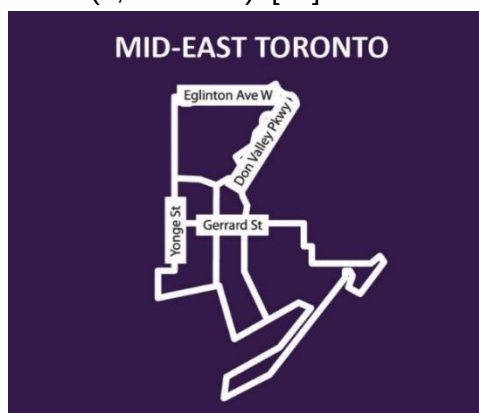
Ethnically and racially diverse population with pockets of high marginalization and seniors living alone. Data Source [4]

Mid-East sub-region overview:

- Six of nine neighbourhoods have rates of low income (after tax) higher than the Toronto Central LHIN average (20%). Socio-demographics are changing due to gentrification. [25]
- Highest proportion of seniors living alone (43.2%) in Toronto Central LHIN, highest in Church-Yonge Corridor (54.5%) and Moss Park (53.3%) neighborhoods. [5]
- Most heavily represented visible minorities are East Asian, South Asian and Blacks. The most common languages spoken other than English include Chinese (including Cantonese and Mandarin), Tamil, and African languages (e.g. Bantu languages and Amharic). [6]
- Regent Park and North St. James Town have particularly high levels of marginalization. [7]
- Second highest number of homeless shelters in the LHIN (21) (most in Moss Park, and Church-Yonge Corridor) with the highest number of beds (2,030 beds). [17]

Health status:

- Second lowest rate of total hospital births women aged 15-49: 31.2/1000 (2012/13-14/15). [8]
- Lowest number of deaths (770) and second lowest crude death rate (537.0/100,000 population) among sub-regions in 2011. [9]
- Particularly high rates for all chronic diseases among the Sub-Regions for adults 20+ years and older. [10]



Primary care and other health service providers:

- 213 primary care physicians, 56% in Community Health Centres and Family Health Teams (highest proportion in all sub-regions). [11,12]
- Neighbourhoods with the lowest levels of continuity of primary care include Waterfront Communities-The Island (26.9%), Moss Park (25.4%), and Church-Yonge Corridor (24.9%). [13]
- Main hospital is St. Michael's. Highest concentration of Community Mental Health and Addiction agencies (24), high number of Community Support Services (15) and 4 Long-term Care Homes [1]. High number of health/community providers serving the Indigenous population.

Health service utilization:

- 25.7% (14,437) of total visits to Emergency Department (56,259) were of low urgency 2015/2016. [14]
- 11,781 hospital separations in 2015/16. 14.6% of the total number of hospital inpatient days were designated as Alternate Level of Care. [15]

MID-WEST TORONTO

305,989 residents
19 neighbourhoods
7977 people/sq km

Ethnically diverse immigrant population, low socio-economic status in some areas

Data Source [4]

Mid-West sub-region overview:

- Highest proportion of immigrants (41.6%), but relatively low rate of recent immigrants (6.1%). [6]
- Highest rate of individuals with no knowledge of English or French compared to other sub-regions. Most common non-English languages are Portuguese, Chinese, Spanish & Italian. [4]
- Kensington-Chinatown, Weston-Pellam Park, and Keelelesdale-Eglinton West have particularly high levels of marginalization. [7]
- Mid-West has the highest number of homeless shelters in the LHIN (22) (most in Kensington-Chinatown, followed by Niagara and Annex) with a total of 1,099 beds. [17]
- Neighbourhoods in lower part of the sub-region experiencing high growth rate due to revitalization of waterfront. [17]

Health status:

- Lowest rate of total hospital births to women aged 15-49 rate: 30.3/1000 (2012/2013-2014/2015). [8]
- Second highest number of deaths (1,633) but lowest crude death rate (534.2/100,000 population) among sub-regions in 2011. [9]
- Low prevalence of chronic diseases compared to Toronto Central LHIN in 2014/15. Weston-Pellam Park and Keelelesdale-Eglinton West had remarkably high prevalence across the neighbourhoods for all diseases. [10]



Primary care and other health service providers:

- Highest number of primary care physicians (491) with approximately 29% in Community Health Centres or Family Health Teams. [11,12]
- High proportion of people with low primary care continuity (21.3%), with highest rates of low continuity seen in Niagara (29.2%) and Waterfront Communities-The Island (26.9%). [13]
- Has three academic hospitals (Sinai Health, University Health Network and Women's College Hospital) and two specialty hospitals (Centre for Addiction and Mental Health and The Hospital for Sick Children) leading to high inflow of patients from outside the sub-region.
- High number of Community Mental Health and Addiction agencies (20), Community Support Services (13) and 12 Long-term Care Homes located in the sub-region. [1]

Health service utilization:

- 25.7% (30,799) of total visits to the Emergency Department (120,034) were of low urgency. [14]
- 17.4% of the total hospital inpatient days were designated as Alternate Level of Care.

NORTH TORONTO

199,051 residents
13 neighbourhoods
5125 people/sq km

Overall older population with high socio-economic status, with few areas of high proportion of children, low income and cultural diversity.

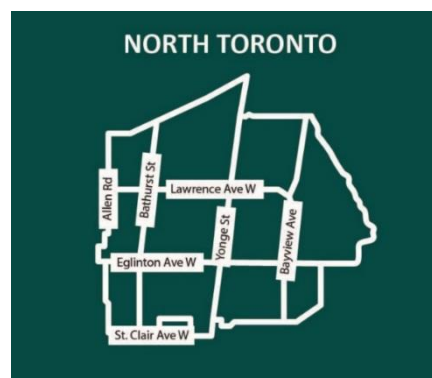
Data Source [4]

North sub-region overview:

- Highest proportion of seniors above 65 years in 2011 (14.7%) amongst sub-regions, and the 2nd highest rate of seniors living alone (38%), highest rate in Mount Pleasant West (58.2%).
- Proportion of children and youth (ages 0-19) in North Toronto was higher (20.3%) in 2011 relative to Toronto Central LHIN (18.7%). [5]
- Overall, highest income among sub-regions, with Bridle Path-Sunnybrook-York Mills having highest median household income in 2011 (\$161,448).
- Englemount-Lawrence neighbourhood in particular has a high needs population; high proportion of immigrant population, residents with low income (after tax) (25.5%) and in need of social assistance (12.4%), and high rate of seniors living alone (41.6%). [5]
- There is diversity in languages spoken, the most common non-English languages include Tagalog, French, Persian (Farsi), Spanish and Russian. [4]

Health status:

- Rate of total hospital births to women aged 15-49: 36.5/1000 (2012/2013 to 2014/2015). [8]
- 1,212 deaths with a crude death rate of 608.9/100,000 population in 2011. [9]
- Lowest prevalence rates for Diabetes, Mental Health Visits and chronic obstructive pulmonary disease (COPD) of all sub- regions. [10]



Primary care and other health service providers:

- 215 primary care physicians, 11% in Community Health Centres and Family Health Teams [11,12]
- Better continuity of primary care for enrolled and non-enrolled residents compared to other sub-regions. Neighbourhoods with the lowest levels of continuity include Humewood-Cedarvale (22.9%), Forest Hill North (22.4%) and Englemount-Lawrence (22.2%). [13]
- 3 academic hospitals (Sunnybrook, Baycrest and Holland Bloorview), 10 Community Support Services, 3 Community Mental Health and Addictions agencies and 3 Long-term Care Homes. [1]

Health service utilization:

- 23.8% (13,373) of total visits to Emergency Departments (56,148) were of low urgency. [14]
- Highest rate of cancer screenings for eligible populations. 14,784 hospital separations.
- 15.6% of the total number of hospital inpatient days were designated as Alternate Level of Care. [15]

WEST TORONTO

231,805 residents
15 neighbourhoods
4638 people/sq km

Overall high socio-economic status, with areas of high proportion of children, low income and cultural diversity

Data Source [4]

West sub-region overview:

- Slightly higher proportion of children and youth (ages 0-19) in 2011 (20%) compared to Toronto Central LHIN (18.8%). 11.3% growth in High Park Swansea 0-19 year olds – 2006-2011. [5]
- Highest proportion of residents who speak English (85.3%) among sub-regions; most common non-English languages include; Spanish, Polish and Portuguese. Half of the neighbourhoods of West Toronto have a higher percentage than Toronto Central LHIN of seniors living alone (High Park North, New Toronto, and South Parkdale over 40%). [5]
- Particularly high levels of marginalization [7] in specific neighbourhoods. South Parkdale in particular has a high needs population; high proportion of recent immigrants, persons living below low income measure, population receiving social assistance, unemployed and high marginalization rate.

Health status:

- Second highest rate of total hospital births, women aged 15-49 - 38.8/1000 (2012/2013 -2014/2015). [8]
- 1,518 deaths with the highest crude death rate (652.6/100,000) among sub-regions. [9]
- Slightly higher prevalence of chronic diseases compared to Toronto Central LHIN. Mount Dennis, New Toronto and Rockcliffe-Smythe are characterized by high prevalence rates. New Toronto had remarkably higher rates across all conditions apart from diabetes (FY2014/2015). [10]



Primary care and other health service providers:

- 180 primary care physicians, 26% in Community Health Centres and Family Health Teams. [11,12]
- Slightly lower proportion of adults with low primary care continuity (25.9%) compared to Toronto Central LHIN (26.1%). Neighbourhoods with the lowest levels of continuity include; Rockcliffe-Smythe (24.8%), Mount Dennis (24.6%) and New Toronto (24.3%). [13]
- Main hospital is St Joseph's Health Centre, 2 rehabilitation/complex continuing care hospitals, 9 Long-term Care Homes, 8 Community Mental Health and Addictions, and 5 Community Support Services agencies. [1]

Health service utilization:

- 28.8% (28,818) of total emergency department visits (100,172) were of low urgency. [14]
- 15.7% of the total hospital inpatient days were designated as Alternative Level of Care. [15]

Overview by Goal

Over the next four years Toronto Central LHIN will be guided by the following three overarching goals:

A Healthier Toronto

Until recently, health planning captured only those coming through the doors of the health care system, leaving behind those who need care but are not connected to services. As a consequence, we have missed many opportunities to improve health in our city.

We recognize that in the wide spectrum of social determinants of health, health care makes only a small contribution to the overall picture of what impacts the health of an individual. Improving health will require close collaboration with the many other partners, inside and outside health, who share this vision.

Although our goal is to improve the health of everyone, we recognize that the path to getting there will be different for the diverse communities throughout the city. Whether characterized by income, social, racial or ethnic factors, many communities get less benefit from the health care system than others. These differences often reflect disparities in access or other barriers to care. We will build on our understanding of these unique needs and drive the development of targeted solutions that will improve health equity across these groups.

As well, we continue to work closely with the City of Toronto to strengthen our partnership and work collaboratively to address social determinants of health and improve the health of our residents together.

Positive Patient Experiences

We want a health care system that is more responsive to patients, cost-efficient, higher quality, and easier to navigate. We believe that this can only be achieved when excellence in health outcomes is matched with positive patient experience.

Impacting the patient experience involves leveraging the knowledge of patients, families and other informal caregivers in planning and decision-making. The incorporation of these perspectives ensures that care plans will be appropriate and ultimately more effective in improving patient outcomes.

To do this, the Toronto Central LHIN has launched a Citizen's Panel, a group of patients, caregivers and residents, who will work in partnership with us to improve local health care. The panel will help the LHIN align our planning and strategy with the needs and priorities of those who touch our health care services every day.

Our goal is to achieve a patient experience that is:

- seamless, where transitions are barrier-free across sectors and facilities;
- supported by open and effective communication between patient and provider as well as, across providers;
- culturally appropriate and culturally competent, and
- inclusive of family and caregivers – across all generations.

System Sustainability & Innovation

In order to ensure that we can meet the needs of Ontarians today and in the future, the health care system must be sustainable and transparent. The system is operating within a tight fiscal environment. While this brings challenges, it also presents opportunities to explore innovations that drive quality and value from our health care investments. Key to the sustainability of our health care system is the importance of ensuring that care is happening in the right place at the right time.

A key enabler to developing and leveraging innovation across Toronto Central LHIN is our partnership with hospitals in our LHIN. The fact that the Toronto Central LHIN has the largest concentration of Academic Health Science Centres within our geography is a unique and positive opportunity that should be recognized in our strategic plan. Our academic hospital partners provide ongoing leadership in system transformation, research, and innovation which, is often utilized in LHIN planning and project design to develop innovative programming or solutions to common barriers. Our strong community and specialty hospitals partnering with our AHSC hospitals all contribute to a world class hospital sector.

Recognizing that hospitals are important resources within Toronto Central LHIN is critical to ensuring that we continue to build on established partnerships so that we may achieve our goals of transformation within the primary and community care sector, taking a population health approach, and designing health care for the future.

Our ability to achieve these goals relies on careful, data driven capacity planning and on designing the system to fully leverage our resources across the entire spectrum of health care. This plan will ensure that we are able to meet the needs of the population in our catchment area, while supporting and maintaining the critical role our health care partners play in providing specialized services to the province.

Enhanced performance measurement, reporting and performance management will help to safeguard quality.

Health Service Providers

Toronto Central LHIN disburses \$4.79 billion into the local health care system. Details of these transfer payments are as follows:

HSP Funding 2015/16	Total (\$)	% of Total Funding
Operation of hospitals	3,580,546,410	75%
Long-term care homes	274,101,551	6%
Community Care Access Centre	250,907,414	5%
Community Support Services	104,091,661	2%
Assisted Living Services in Supportive Housing	57,894,669	1%
Community Health Centres	93,491,259	2%
Community Mental Health Addictions Program	138,782,566	3%
Addictions Program	38,299,857	1%
Specialty Psychiatric Hospital	260,990,443	5%
Total	4,799,105,830	100%

*Based on 2015-16 Actual - Audited Statement: [18]

WE PLAN, FUND AND COORDINATE

services delivered by a large number of providers, including:



Data source: [1]

Performance Management

Response to Auditor General Report

On December 4, 2015, the Office of the Auditor General of Ontario (OAGO) released its 2015 Annual Report including a LHIN value-for-money audit. In this report, there were some recommendations for LHINs to: improve health system performance and address variability, improve internal performance management practices, and improve alignment of measures and indicators. Toronto Central LHIN welcomed the recommendations and is continuing to work closely with the Ministry of Health and Long-Term Care and other LHINs to implement them. The solutions that arise from the recommendations will continue to strengthen performance and quality across Ontario.

Ministry LHIN Accountability Agreement (MLAA)

Toronto Central LHIN has developed a performance improvement plan focused on Ministry-LHIN Accountability Agreement indicators for 2016/2017 and 2017/2018. Toronto Central LHIN expects to meet 9/14 performance indicators by the end of the agreement (March 31, 2018).

Environmental Scan

Provincial Considerations

As the LHIN is influenced by provincial directions, it is critical that our new strategic plan aligns with provincial priorities related to the Patients' First Act (The Act). The Act emphasizes the collaborative nature of health care, indicating the need for co-operation between sectors. Fiscally, the province of Ontario is still significantly restrained which has obvious implications for our LHIN and health service providers, whilst the expectations for health care delivery remains high.

Recognizing that LHIN boundaries should be invisible to patients and that there are standards that everyone should be able to expect regardless of where they live, the 14 LHINs across Ontario have engaged in collaborative planning. The 14 LHIN Chief Executive Officers have developed the following four strategic directions to guide their next round of planning at the individual LHIN level:

- 1) Transform the patient experience through a relentless focus on quality;
- 2) Build and foster integrated networks of care;
- 3) Tackle inequities by focusing on population health; and
- 4) Drive innovative and sustainable service delivery.

Stakeholder Considerations

Previous stakeholder feedback related to the development of the strategic plan revealed six key themes, each having an important influence on the future direction of Toronto Central LHIN. These themes have been central to ongoing evolution and implementation for the LHIN Strategic Plan.

Focus on Patients

While many patients indicated that they often receive excellent care from individual care organizations, coordination and communication across organizations can be improved. While providers assert that they deliver patient-focused care, they are quick to concede that there is much room for improvement. The creation of tools by the LHIN such as the patient-oriented discharge summary help to improve communication and patient transitions between organizations.

Population Health & Equity

Planning across different sectors is critical to improving the health of the broader population. This means continuing our planning in conjunction with housing, social services, justice, emergency responders and many other partners in the community. Through consultations, we heard that Toronto Central LHIN is effective at identifying sub-sets of the population that have poor health outcomes relative to the rest of the population, and in implementing targeted approaches to improve the health of that specific group. This work needs to be scaled up to other populations in need.

Community Care

Shifting funding and support to strengthen community services is a priority, and it was identified that measuring quality of care is critical to assessing the impacts. Beyond beds and spaces, developing and providing tools and technology were identified as opportunities for Toronto Central LHIN to provide support and leadership. For example, community providers suggested developing a common electronic medical record and integrated back office systems to strengthen the sector as a whole.

Cross-LHIN Collaboration

Stakeholders and providers identified some challenges when residents need services and care is delivered across LHIN boundaries. As many of the large academic hospitals are located in downtown Toronto, residents who live outside of Toronto Central LHIN will often seek treatment here, and then return to their own community for primary and follow-up care. Similarly, many individuals who live outside of Toronto Central LHIN, but work downtown will seek primary health care services during the day within the LHIN. These situations must be considered when working towards integrating care across LHIN boundaries. It is critical that the LHINs work together to coordinate care across LHIN boundaries and to ensure that, from the patient's perspective, they experience a true *system* of care.

Role of Toronto Central LHIN

Toronto Central LHIN and its staff currently function as collaborators, conveners, facilitators and leaders. These roles need to continue and evolve. Work by Toronto Central LHIN is seen by its care partners and the Province as innovative, and it contributes to the provincial agenda by engaging key partners in moving forward new and advanced ideas. An example of these innovations include: our seminal work in establishing Local Collaboratives at the Sub-Region Level; connecting primary care to the broader system through networks; development of a Population Health Approach in health care; creation of an Integration Framework for service providers and; use of data and qualitative patient stories to better assess need and to identify solutions at the local level.

Risk Assessment

Toronto Central LHIN represents a diverse population of 1.3 million people (2015 estimates) [19]. In 2011, Toronto became North America's fourth largest city and the population is growing [20]; in fact the rate of growth in the downtown core is outpacing the rest of the City of Toronto [21]. The fastest growing age group in the city is seniors and this group is expected to make up one-fifth of Toronto's population by 2031. [22] Toronto remains a multicultural hub with the highest percentage of immigrants in Canada. One-third of Toronto's immigrants are newcomers, having arrived in Canada within the last 10 years. [23] Over 140 languages are spoken within our city. [24] This unique city is home to some of the richest and poorest neighbourhoods in Canada, with 26% of residents living in low-income households. [25] Additionally, The City of Toronto population includes 59,000 Francophones, [26] approximately 5,300 homeless [27], the largest lesbian, gay, bisexual and transgender communities in Canada and a rapidly growing urban Aboriginal population, many with complex health needs. These characteristics shape how people interact with the health care system and consequently, affect how we as planners design the system to meet their needs.

Key Risks

Rapid growth in downtown Toronto core

The rapid intensification of the downtown core poses challenges to the health care system. Growth is dramatic in the downtown and it is cumulatively larger than what has been previously acknowledged in planning estimates. To provide context in referring to the growth in Toronto Centre it should be noted that Toronto completed almost 128,650 dwelling units in the past decade, averaging 12,865 units per year over the last ten years. [28] Since 2006 the downtown core has grown by 18%, four times the rate of the remainder of the City, while the population south of Queen Street has doubled in recent years. [21]

Toronto's hospitals are seeing many more people in the emergency department and these people are very sick. Toronto Central LHIN has received the City of Toronto Population Growth study to understand the demographics of the population in the high growth areas to determine the appropriate action.

From a community sector perspective, clients supported by the CCAC each year are increasingly complex and caseload sizes continue to expand thereby putting further pressure on community resources.

Long-Term Care Home Capacity

There are two major pressures in the long-term care sector in Toronto: increasing resident complexity and the redevelopment of Long-term Care Homes (LTCH) where land-locking and financial barriers present unique urban challenges to renewal.

There is a high probability that in the future, Toronto Central LHIN will lose a significant proportion of LTCH beds, as operators choose to leave and locate outside of Toronto due to the high costs of building and operating in the city. LTCHs are operating at above 99% occupancy and the median time for a client to be placed in a LTCH within the LHIN is higher than the provincial average. [29] At the same time, LTCH residents have increasingly more complex needs, requiring specialized services that many homes are currently not equipped to provide. Further loss of LTCH beds would have an impact on Toronto Central LHIN's emergency room wait times, alternate level of care (ALC) performance and patient access to the appropriate level of care.

To address this risk, Toronto Central LHIN and Central East LHIN collaborated on the first phase of a long-term care capacity plan. This work will continue in the year ahead with a focus on LTCH redevelopment in Toronto, and recommendations on the size and type of services necessary to meet current and future resident's needs.

Long-Stay Alternate Level of Care (ALC)

Toronto Central LHIN has seen an increase in the number of long-stay patients over the last number of years. Over 38% of patients designated ALC have an average length of stay of more than 190 days and they are waiting for long term care and supportive housing; and over 20% are non-Toronto Central LHIN residents. [30] The Toronto Central LHIN with its health service providers is currently looking at options for long-term substitution and collaboration opportunities with Toronto Housing Corporation to enhance access and the Toronto Central LHIN has developed a proposal to increase short-term transitional capacity.

Mental Health and Addictions

Toronto Central LHIN has a significant shortage of community-based addiction and mental health programs. In response, the LHIN is developing a comprehensive plan to address some of the service gaps, and to decrease the number of Emergency Department (ED) repeat visits and avoidable use of ED by mental health and substance abuse patients.

Community Funding

The proportion of community sector patients receiving care for more than six months remains high due to lack of long-term care bed available in Toronto. Even though community sectors client volume growth has been steady over the last few years, the average level of complexity in community sector has increased at the same time as a result of efforts to reduce ALC in hospitals and the decanting of low acuity patients to community HSPs.

Community Service Pressures for an Aging Population

There has been double digit growth of complex and chronically-ill clients over the past 8 years and this surge is expected to continue. While the increases in demand for CCAC services are currently within tolerant ranges, there are concerns about long-term sustainability, as program spending continues to slowly rise above budgeted amounts. The sustained shift towards greater

client complexity is indicative of organizational strategies to support the Patient's First agenda and Ministry/LHIN priorities on strengthening home and community care and supporting clients with complex care needs for as long as possible. Taken together, these circumstances increase expectations by health system partners, which is compounded by the absence of alternate level of care options since long-term care facilities continue to operate at 99% capacity and hospitals are facing growing resource constraints.

Indigenous

The Toronto Central region is home to approximately 70,000-80,000 Indigenous people. [31] This population is very diverse and includes First Nations, Metis and Inuit people as well as people who identify as Indigenous, non-status, and status. This population is made up of Indigenous people who travel long distances from across Ontario to get health care from regional and local providers, and of people who consider Toronto their permanent home.

The Toronto Central LHIN has a commitment for ensuring health equity for the Indigenous population as this community scores the lowest on all indicators of health and social determinants of health. To this end, Toronto Central LHIN has included Indigenous representation on the Population Health Leadership Table and the Toronto Central LHIN Health Equity Table.

Our LHIN has been supporting the Toronto Indigenous Health Advisory Circle (TIHAC) since its formation in January of 2015. In March 2016, the TIHAC shared the Inaugural Toronto Indigenous Health Strategy with the community. The plan has 24 strategies that are shared by Toronto Public Health, Toronto Central LHIN and the TIHAC itself. The TIHAC is involved in aspects of health planning for the Indigenous community in Toronto and meets once a month to provide input on the action plan of the Toronto Indigenous Health Strategy (TIHS). The TIHAC also has 2 councils, the Elders Council and the Youth Council. The Youth council has been active in beginning work on planning for an Indigenous youth health forum in partnership with other Indigenous youth councils

The elements of the Toronto Indigenous Health Strategy that are currently being actioned include:

- planning for the Indigenous trans and two spirited community;
- a co-planning model for Indigenous palliative care, which includes aligning the work of the Toronto Palliative Care Network and provincial initiatives;
- a strategy to address the needs of the Missing and Murdered Indigenous Women and Girls inquiry that is coming to Toronto in the spring of 2017;
- a sub-committee to action the mental health and addictions strategy; and
- Indigenous cultural safety training.

French Language Services

The City of Toronto is home to approximately 59,000 Francophones. [26] Every year, hundreds of Francophone newcomers settle in Toronto, a city designated to offer services in French under the *French Language Services Act*.

The LHIN has a deep understanding of the role that culture and background play in affecting the health of populations. The LHIN believes that the health system should be guided by a commitment to equity and respect for diversity in communities in serving the people of Ontario and respect the requirements of the French Language Services Act (FLSA) in serving French-speaking communities.

We uphold key pillars which guide our strategy to continually assess and improve the provision of French Language Services

- Promote health equity, and reduce health disparities and inequities
- Respect the diversity of communities in planning, design, delivery and evaluation of services, including culturally safe care for Indigenous people and meeting the requirements of French Language Services Act

In doing so working with Reflet Salvéo, Toronto Central LHIN's assigned French Language Health Planning Entity, community stakeholders and health services providers in our area to ensure a health system that is responsive to the needs and concerns of the Francophone communities. Work is underway to develop a robust system of service providers who have the capacity to serve the needs of this community is the core tenant of the Toronto Central LHIN FLS Strategy. This involves ensuring adequate representation of Francophones at all levels or organizations and securing sufficient French-speaking staff to be able to guarantee access to quality services offered in French by competent and culturally-sensitive staff members.

Active Offer is a critical component to foster French Language Services delivery within patient-centered health care. To strengthen and build organizational capacity, Toronto Central LHIN supported the development of a three-day workshop targeted at 70 Health Services Providers in the implementation of a systemic approach to the Active Offer of French Language Services.

Francophone communities were consulted on the LHIN Population Health Strategy and on Patients First Act. Designated HSPs fully participated on the collaborative work within the LHIN implementation of the sub-regions.

With the integration of CCAC and LHIN organizations, the LHIN will be taking on the responsibility for the provision of home and community care services. The LHIN took the opportunity to foster collaborative work between the Toronto CCAC and designated Francophone agencies for coordination, interaction and collaboration specific to the improvement of FLS to ensure that quality services in French will be maintained post-transition and beyond, or whenever possible enhanced. Careful consideration has been on exploring a variety of models for care coordination that will have the most impact on the provision of French language services for Francophones, including embedding Care coordinators within designated

service providers as well as improving public information enabling patients to locate available services in French.

The LHIN is drafting a FLS Policy that clearly states the importance of providing language appropriate services to ensure the safety and well-being of clients and contribute to enhanced Francophone client experience. This is a shared responsibility between the LHIN and its funded service providers.

Consequently, through their respective Service Accountability Agreements, all HSPs are required to participate in French Language Service (FLS) planning and to report annually to the LHIN:

- For identified HSPs that provide services in French, develop a FLS plan and demonstrate yearly progress towards meeting designation criteria.
- HSPs that are not identified for the provision of FLS, the expectation is to identify their French-speaking clients. This information is to be used by the HSP to help with the establishment of an environment where people's linguistic backgrounds are collected, linked with existing health services data and utilized in health services and health system planning to ensure services are culturally and linguistically sensitive.

The LHIN has started a designation readiness assessment to determine which identified HSP may be ready to transition to designated status and hence increase capacity to offer services in French.

Strategic Priorities and Operational Objectives

Designing Health Care with Citizens	Taking A Population Health Approach	Transforming Primary and Community Care	Achieving Excellence in Operations	Leading and Supporting Our People
1.1 Put Patients and Caregivers at the forefront	2.1 Advance local population-based planning, service alignment, integration, and performance improvement	3.1 Support a system of integrated primary care	4.1 Develop, implement and evaluate a model for performance measurement and management	5.1 Release time to care and lead
1.2 Redesign care and funding for priority clinical populations	2.2 Advance shared goals with the City of Toronto	3.2 Design, implement, and evaluate a model of integrated care for home and community based care (home care, CSS, CMH&A)	4.2 Expand excellence in communications and engagement	5.2 Support people through health system transformation
1.3 Support integration of services	2.3 Improve population health and equity in partnership with Toronto Public Health	3.3 Complete joint planning with CCAC to deliver on provincial direction for home care	4.3 Combine system oversight with service delivery and service management	5.3 Celebrate and recognize staff
1.4 Improve communication and connectivity between HSPs through Sub Region Local Collaboratives			4.4 Improve HSP organizational efficiency and effectiveness	5.4 Create a strong culture and shared values
1.5 Support new and innovative approaches to care delivery			4.5 Successfully complete seamless integration of CCAC and LHIN organizations	
1.6 Support patients / clients in appropriate settings (home, assisted living, LTC, etc.)				

*Strategic priorities have been updated to reflect transition in 2017/2018.

Integrated Health Service Priorities

Designing Health Care with Citizens

Ontario's health care system is undergoing a fundamental shift in the way we think about, plan for and fund health care services.

Key enablers to deliver on this Strategic Priority:

- Improve patient outcomes and increase value through re-alignment of funding mechanisms
- Increase adoption of evidence-based care and strategies
- Promote iterative change in current delivery models to align to broader health care system objectives
- Improve transitions and access to services using eHealth technologies

Approach to Delivering on this Strategic Priority

By leveraging the best available evidence and data, the LHIN will develop and/or redesign services and programs in order to ensure they are grounded in the local context and reflect patients' experience of their journey through the system. The LHIN will maximize the use of new and emerging technologies to drive this work forward.

Status

Citizens' Panel

Understanding and integrating patient experiences will ensure that services are most efficient in meeting needs and improving health outcomes. Toronto Central LHIN has developed a Citizens' Panel to address the following objectives:

- inform and strengthen the work of the LHIN to help maintain currency and relevancy
- provide stakeholders (residents, patients and caregivers and health care partners) with balanced and objective information on issues that affect their health and/or work
- understand the needs and priorities of those we are designing the health system for and to make decisions that are informed by their perspective
- inform Toronto Central LHIN programs and services, specific initiatives including integrations and capital planning, the design of new projects and changes to existing ones.
- engage members of the Toronto Central LHIN on LHIN priorities and initiatives and to support additional engagement opportunities

Local Collaboratives

Our standard of excellence is no longer a system where each provider does a first-rate job on their discrete piece of patient care. We are now focused on whole episodes of care, ones that better reflect the way that patients see their journey through the system as they move from primary health care, to hospitals, to the community.

In May and June of 2016, we held our first round of cross-sector meetings within each sub-region

planning area. The purpose of these meetings was to bring all types of providers together, with our common ground being the communities that we serve. This group of local providers within a sub-region planning area is our *Local Collaborative*. The Local Collaboratives met again in October/November as well as in January 2017 to continue to build partnerships, review the health needs of residents living within our sub-regions, and to begin to identify starting points for performance and quality improvement.

Local Collaboratives will be better positioned to identify unmet needs, health inequities, and work with communities to identify outcomes that are important to them – whether they be on a neighbourhood basis, or within specific types of population groups. A thorough analysis of the data will allow Local Collaboratives to be able to focus on the populations where there are the greatest opportunities for improving health outcomes. Fiscal Year 2017/2018 will be a year of significant engagement of communities to develop strategies and solutions that are significantly shaped by the patient voice.

Patient Pathway Redesign

Clinical services that are designed around the needs of the patient often span multiple sectors from acute, to community and primary care. They are framed not as an episode of care, but rather as the continuum of care that reflects the patient journey. The goal of redesign is to ensure the best outcome for the patient and the system. This includes care pathways that provide the most direct route for getting safe, effective (patient outcomes) and appropriate care (system outcomes).

Strategic Integration

Voluntary, facilitated, and directed integrations are tools for delivering a more coherent and sustainable system. The redesign of service pathways and work to transform community care will yield opportunities for organizational integration.

In December 2015, Toronto Central LHIN launched a third-party review of integrations. The aim of the review was to make recommendations to improve on the success of the voluntary integration process, as well as how success can be achieved in Toronto Central LHIN-led or facilitated integrations. The integration review was led by a committee of cross-sector health service provider representatives. The final report from the review, [*Advancing the Integration Conversation*](#) is available on our website.

The report contains seven recommendations to Toronto Central LHIN in response to the three initial questions that launched the third party review:

- *How does Toronto Central LHIN sustain success in voluntary integrations?*
- *How does Toronto Central LHIN successfully lead facilitated integrations?*
- *Where should Toronto Central LHIN look to lead facilitated integrations?*

Toronto Central LHIN has an approved plan to implement the recommendations from the third party review, *implementing the Integration Program*. The plan will be implemented over three years, and will link the recommendations from the review to the three questions above.

Implementation efforts will also be linked with other major workstreams of Toronto Central LHIN, such as but not limited to, Sub-Region Local Collaboratives, and the Integration of In-Home and Community Care. Key to the success of the implementation plan is imbedding the fundamental principles that:

- **Integration activity is about Improving Services to Patients and Clients.** As such, all health service providers and LHINs have an obligation to consider integration opportunities.
- **Integration consists of a Spectrum of Activity**, as outlined in the third party review. This spectrum ought to be considered by all providers and Toronto Central LHIN, both individually and collectively, as part of continuous quality improvement efforts for patient and client services, as well as regular strategic and operational planning processes.

Planned integration activity for 2017/18 includes, but not limited to:

LHIN Initiated Integrations

Improved services to patients and clients is the goal of all integration activity to enhanced client services and improved system performance. Integrations led by Toronto Central LHIN involve all options in the full spectrum of integration activity.

Toronto Central LHIN has identified an initial list of community service integration opportunities based on high volume, multiple providers, and variation in performance metrics. These services account for approximately 65% of the Toronto Central LHIN allocation for community services.

In 2017/18, Toronto Central LHN is initiating discussions on Mental Health Case Management Supportive Counselling and will start the facilitated integration of Residential Mental Health Support within housing.

Toronto Central LHIN Local Collaboratives will be the platform to engage local health system leaders in facilitated integrations. The Local Collaboratives will also be engaged in facilitated discussions on identifying overall integration options to advance population health outcomes, service capacity improvements and desired patient and client services within the variety of services available locally. The goal is to imbed continuous quality improvement practices that challenge the status quo in service delivery, and strives for improved services for clients.

Voluntary Integrations: Toronto Central LHIN will continue to support voluntary integrations that lead to improved patient and client services. There are currently four voluntary integrations underway for completion in 2017/18, and more are expected to come forward during the fiscal year.

Of particular interest is the development of a “Back Office Integration Model”. Several health service providers are leading this work and will present a model in early 2017/18. Toronto Central LHIN expects to test the model in 2017/18 either within a Local Collaborative, or LHIN-wide.

Supporting Innovation

As demands on the health system change, innovative solutions are required to keep the population healthy. Innovation silos exist and leading practices are not always effectively shared and implemented across the system. The LHIN must maintain some flexibility to respond to emerging opportunities and changing environments. Adopting a culture of innovation will include supporting spread and scale of successful initiatives, and keeping a small amount of funding to support this work is essential to addressing local needs. Funding may be used to evaluate promising practices and to support implementing evidenced-based approaches in the rest of the system.

Quality Improvement

Developing quality indicators relevant for driving clinical and service planning changes is a provincial-level priority. As this work is carried out at provincial tables, we need to tailor this work and develop local regional implementation plans.

Digital Health Strategy

Information technology and information management are key elements in empowering patients and connecting the various sectors of the health care system. They eliminate duplication allowing patients, family caregivers, and service providers to share information and coordinate services quickly and efficiently as people transition through the care continuum.

Leveraging information management and information technology investments made at the local, regional, and provincial levels will drive health care transformation and enable informed system planning decisions. Solutions implemented in the next three years will be reflective of the Integrated Health Service Plan's strategic framework.

Goals of this Strategic Priority

- Align funding and service design with specific targets for improved patient outcomes;
- Engage diverse populations in service redesign;
- Work with health service providers to re-organize the system to enable strategies based on the best available evidence;
- Integrate the patient experience by allocating funding to the patient journey rather than individual tests, visits and procedures;
- Leverage funding tools to encourage health service providers to align their services with broader health care objectives;
- Encourage strategic integration of services; and
- Use Toronto Central LHIN's local datasets to plan for the implementation of the Ministry's long-term plan for the capacity of the health care system.

Work with local partners and other sectors to expand access to mental health and addictions services that:

- Expand access to structured psychotherapy and supportive housing
- Establish referral networks with primary care providers

- Make access to community mental health services a priority for sub-region planning, in collaboration with community and social service providers and partners
- Support the provincial opioid strategy, and provide support to connect patients with high quality addictions treatment.

Consistency with Government Priorities

Local strategies to improve system flow, lower hospital admission rates and reduce Alternate Level of Care (ALC)

In 2015-16, the Toronto Central LHIN has endorsed and facilitated the refinement and adoption of the ALC Avoidance and Management Framework by all TC LHIN hospitals. This framework has since been identified as a leading practice by the Provincial ALC Advisory Committee with implementation across the province being planned.

During the second year of the three-year mandate, Toronto Central LHIN has invested resources to reduce hospitals and long-term care demand, through the Short Stay Reintegration Beds at St. Hilda's, Home and Community Care initiatives where Community Support Services providers are supporting transitions from hospitals.

Enhance existing and develop new performance and quality measurement frameworks that are consistent and flexible to address regional priorities and drive innovation, collaboration and best practice.

Toronto Central LHIN is currently developing a framework to identify and select innovative processes, practices, and initiatives for spread across our geography. Additionally the LHIN continues to work with providers and partners as a primary sponsor for innovation funding opportunities with respect to new tools. For example expansion of Patient Oriented Discharge Summaries (PODS) across the province, which was a solution originally co-designed by patients and implemented in hospitals within the Toronto Central LHIN.

Establish and engage our Patient and Family Advisory Committee to ensure patients and families are involved in health care system decision-making

The Toronto Central LHIN's Citizens' Panel was established in April 2016. The panel consists of 18 diverse members who have used their combined experiences, values and priorities to inform the work of the Toronto Central LHIN, which is striving to embed the patient and community voice in every program it supports. As the Toronto Central LHIN moves towards a sub-region approach to planning, we want to strengthen the Citizens' Panel ability to participate in co-designing the healthcare system and to involve them in everything we're doing.

DESIGNING HEALTH CARE WITH CITIZENS: ACTION PLAN

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"	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
1.1 Put Patients and Caregivers at the forefront of our program design						
a) Continue to strengthening the Citizens' Panel (Patient and Family Advisory Council)	In progress	50	Complete	50		
b) Design and Implement plan for Community Engagement in Sub-Regions	In progress	50	Complete	50		
1.2 Redesign care and funding for priority clinical populations						
a) Create regional planning framework	In progress	75	Complete	25		
b) Continue implementation of the MOHLTC Integrated Funding pilot projects	In progress	50	In progress	40	Complete	10
c) Create Toronto Central LHIN Integrated/Bundled Funding model (IFM) pilots	In progress	50	Complete	50		
d) Develop pathways to support improvement of MLAA indicators for Hip & Knees	Complete	100				
e) Expand best practice care for Chronic Heart Failure (CHF), Chronic Obstructive Pulmonary Disorder (COPD), and Pneumonia	In progress	25	In progress	55	In progress	20
f) Improve access to high quality palliative care in alignment with OPCN.	In progress	40	In progress	40	In progress	20
1.3 Support integration of services						

a) Develop and implement an integration framework to encourage and facilitate integration of services	In progress	75	Complete	25		
1.4 Improve communication and connectivity between HSPs through Sub-region Local Collaboratives						
a) Harmonize existing LTC outreach services (Behavioral Supports Ontario, etc.)	In progress	50	Complete	50		
b) Implement a Toronto Central LHIN wide digital health plan	In progress	75	Complete	25		
1.5 Support new and innovative approaches to care delivery						
a) Create an innovation program with framework to identify, spread and scale innovations across Toronto Central LHIN	In progress	50	In progress	25	Complete	25
1.6 Complete capacity planning in order to support patients / clients in appropriate setting (home, assisted living, LTC, etc.)						
a) Implementation of recommendations and actions from the Toronto Central LHIN Long-term Care home capacity plan	In progress	30	In progress	40	Complete	30
b) Complete City of Toronto population growth impact study	Complete	100				

How will we measure success?

Designing Health care with Citizens	MLAA	Other Outcome areas of focus
1.1 Put patients and caregivers at the forefront of our program design	Not applicable	Patients' involvement in decisions about their care
1.2 Redesign care and funding for priority clinical populations	- Percentage of Priority 2, 3 and 4 cases completed within access targets for: Hip Replacement* - Percentage of Priority 2, 3 and 4 cases completed within access targets for: Knee Replacement* 90th percentile Emergency Department length of stay for Complex Patients*	Change in trend of proportion of funding between community and hospital care

	- Percentage of Priority 2, 3 and 4 cases completed within access targets for: MRI* - Percentage of Priority 2, 3 and 4 cases completed within access targets for: CT*	
1.3 Support integration of services	Not applicable	Percentage of anticipated outcomes from organizational integrations achieved
1.4 Improve communication and connectivity between HSPs through Sub Region Local Collaboratives	Rate of patients who visit the emergency department for conditions best managed elsewhere**	
1.5 Support new and innovative approaches to care delivery	- Rate of patients who visit the emergency department for conditions best managed elsewhere** - Percentage of ALC Days* - ALC Rate*	
1.6 Complete capacity planning in order to support patients / clients in appropriate setting (home, assisted living, LTC, etc.)	- Rate of patients who visit the emergency department for conditions best managed elsewhere** - Percentage of ALC Days* - ALC Rate*	

What are the risks / barriers to successful implementation?

Risk/Barrier	Mitigation
Requires ongoing partnerships with and between HSPs and other external partners (i.e. City of Toronto).	Toronto Central LHIN will continue developing strong partnerships with external partners and health service providers. Toronto Central LHIN is developing cross-sector collaborative tables to facilitate health service providers working together to develop a shared vision and outline individual and shared commitments to achieving the vision.
Requires enhanced willingness from all HSPs to partner with patients, caregivers and residents to co-design care.	Toronto Central LHIN is encouraging a co-design approach for health service providers by modeling these behaviours at the LHIN level, and incorporating this into our engagement process. The LHIN is asking health service providers to co-design local delivery solutions with patients / clients, caregivers, families, and community members through our cross-sector collaborative tables. Toronto Central LHIN will establish the structure to achieve this.

Integrated Health Service Priorities

Taking a Population Health Approach

Our mandate is to deliver quality health care to all. This commitment is reinforced by Ontario's *Excellent Care for All Act* (ECFAA). The ECFAA states that we, "[s]hare a vision for a Province where excellent health care services are available to all Ontarians, where professions work together, and where patients are confident that their health care system is providing them with excellent health care." Toronto Central LHIN aims to fulfill this vision by addressing the needs of everyone who lives in or receives care within our geographic boundaries.

Planning across the health care system has generally been focused on meeting the needs of those actively receiving health care. Evidence suggests that by adopting a population health approach and by proactively planning for the health needs of all people, both patients and the system will benefit. In taking this approach, we are reorienting the work of Toronto Central LHIN towards activities that aim to improve the health status of the population as a whole, as well as its many sub-populations.

We believe that good health is more than the absence of disease. Reorienting the health care system to take into consideration the broader social determinants of health that go beyond clinical and curative services is a major shift that can only be achieved through long-term strategic partnerships. This includes non-traditional partnerships with organizations outside the health care system, such as shelters, police, housing, and employment centres, to work toward addressing the full range of factors that impact health.

This approach will be greatly facilitated by the Sub-Regions. Smaller geographies fosters the ability to focus on specific populations where the data and community engagement point to the need for tailored strategies and efforts. The local collaborative concept brings a network of providers together with the primary care providers to offer seamless, accessible and integrated services.

Key enablers to deliver on this Strategic Priority:

- Build analytic capacity and data collection across health service providers
- Collect standardized equity data in hospitals and community health centres
- Improve coordinated care for complex clients
- Build strategic partnerships with other sectors, funders, Ministries
- Increase engagement with sub-populations

Approach to Delivering on this Strategic Priority

Adopting a population health approach is a new concept for the LHIN and closer alignment with Toronto Public Health is required before the principles of population health can be fully integrated into the system and into the LHIN's planning.

This strategic priority tackles the building blocks and culture change required for successful population health planning.

Population Health Approach

In January, we launched a Population Health and Equity Strategy Leadership Table co-chaired by Dr. Barbara Yaffe, Acting Medical Officer of Health, Toronto Public Health, and Dr. Kwame McKenzie, Chief Executive Officer of the Wellesley Institute and Director of Health Equity at Centre for Addictions and Mental Health. This Leadership Table is guiding and advising on the LHIN's Population Health and Equity Strategy and its progress.

There are four core components to the **Population Health Strategy**:

- **Health-Based Assessment:** Advancing our understanding of the health of the population residing within the LHIN;
- **Health Equity:** Reducing health inequities within the LHIN;
- **Practice-Based Population Health:** Strengthening providers ability to take a holistic view of the populations they serve; and
- **Strengthening our partnership with Toronto Public Health:** Planning together where we have shared priorities.

Working groups are being established to advance each of the four components and will provide ongoing status updates to the Leadership Table.

This work will play a central role in helping the LHIN to fulfill its mandate from the Patients First Act to:

- Establish stronger links to population and public health;
- Add the promotion of health equity and development and implementation of health promotion strategies; and
- Formally connect and collaborate with boards of health and public health units to leverage their expertise and plan together.

Strengthen Relationship with Public

The LHIN has been building a stronger relationship with Toronto Public Health by establishing a formal partnership, identifying shared priorities and collaborating on population health planning, health equity and health promotion initiatives. The partnership table is co-chaired by the Toronto Medical Officer of Health and the LHIN Chief Executive Officer, and consists of the senior management teams from both organizations. The table met for the first time in November 2016 and will continue to meet quarterly on an ongoing basis. This partnership will be expanded to

include all five LHINs that work within the City of Toronto. Key areas of collaboration that have already begun include: shared population health assessment, surveillance and planning; preventive and primary care focused on perinatal and early childhood health; and opioid use and overdose prevention.

Advancing Health Equity

The Toronto Central LHIN Strategic Plan 2015 - 2018 places renewed emphasis on the importance of taking a population health approach to regional health planning. Integral to this approach is the application of a health equity lens – a first step toward providing everyone in our catchment area with a fair chance to lead a healthy life. A clear and focused health equity strategy is needed for Toronto Central LHIN to operationalize our new and ambitious plan.

There are three pillars to advancing health equity in Toronto:

1. Achieving a change in culture to create a common vision for health equity.
2. Collecting standardized equity data and research.
3. Developing specific local interventions and spread of effective solutions.

This LHIN will focus on the development of targeted approaches to closing the gap in health outcomes for specific populations. As the LHIN becomes more experienced in identifying gaps, engaging populations, and creating targeted solutions, this expertise will be extended to more of the LHIN initiatives.

City of Toronto Strategic Partnership

The City of Toronto and Toronto Central LHIN's collective aim is to improve the quality of life for similar population groups, the City from a social service and social delivery view and the Toronto Central LHIN from a health care view.

Senior leadership from both the City of Toronto and Toronto Central LHIN agree that by aligning our respective resources and efforts, we leverage improved results that are not attainable separately. This is why a close relationship, at both the strategic and operational levels, has been forged, and initiatives established to create an important venue where the health care system and the social services and municipal system can be integrated. This provides an opportunity where both systems that historically operated independently from each other can cooperate to jointly address the needs of our mutually identified priority populations. Progress is being made and the successes of these initiatives will be evaluated to create an important venue where the health care system and the social services and municipal system can be integrated.

The City of Toronto and the Toronto Central LHIN are building on our current accomplishments and close working relationship by establishing an agreement that will focus on a healthier city. Outlining the demonstrated commitment and effort at multiple levels by both partners, the agreement will support a much closer strategic and working relationship between both partners well into the future. A joint Steering Committee between the City and the LHIN has been

established and engagement is underway to define joint priorities that will improve outcomes for Torontonians.

Goals of this Strategic Priority

- Establish accountability for ensuring that all residents within our catchment area have access to services;
- Harness a robust data collection system that captures the unique needs of the communities we serve. This data will support our ability to stratify populations into meaningful groups for planning, allow us to identify health inequities and other unmet needs, and develop appropriate and targeted solutions;
- Work with patients and health service providers within sub populations to implement targeted solutions that bridge gaps in access and appropriateness of care;
- Build strategic relationships with other partners (e.g., City of Toronto, Toronto Community Housing, United Way, Toronto Police Service and Toronto Paramedic Services) to strengthen community and social supports and improve health; and

Consistency with Government Priorities

Work with public health and community partners to improve access care promote health equity at the sub-regional level

Toronto Central LHIN launched the Population Health and Health Equity Leadership table that will provide oversight for key activities. These include the development and implementation of a Health Equity strategy to better serve the needs of marginalized communities; the identification of evidence based approaches to managing population health at the practice level; the development of tools for surveillance and ongoing performance measurement of population health.

Promote health equity and recognize the impact of social determinants of health to reduce or eliminate health disparities and inequalities in the planning, design, delivery and evaluation of services

The LHIN will work with public health and local community partners to identify high-risk populations and deliver targeted interventions to improve access to appropriate and culturally sensitive care, and improve health outcomes, including through sub-region planning.

In doing so, the LHIN will engage with Indigenous leaders, providers and patients to guide investments and initiatives and assess the capacity of health service providers within LHIN sub-regions and the extent to which Francophone citizens are provided with an active offer of health services in French, and develop a plan to strengthen health services in French where gaps are identified.

Assess local population health needs in the sub-region, including patient access, wait times and health provider capacity, and collaborative with local residents and providers to identify priorities

The Toronto Central LHIN has divided its region into 5 sub-regions to provide a foundation for the development of local integrated systems to better understand and address needs at the local level and identify how providers will collaborate to address health gaps, and improve the patient experience and outcomes. Serving as the focal point for population-based planning, service alignment and integration, and performance improvement, local collaborative sessions were organized in each of the 5 sub-regions with representatives of health service providers, members of the Citizen's Panel and local partners from across the Toronto Central LHIN. Facilitated sessions were held in each of the 5 sub-regions in October / November 2016 as well as in January 2017 where a shared vision of the sub-regions was developed, neighbourhood profiles providing a deeper understanding of health care utilization, health status and outcomes and disparities related to certain socio-demographic characteristics were reviewed and groups began to develop and prioritize local action plans for 2017/2018.

TAKING A POPULATION HEALTH APPROACH: ACTION PLAN

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”	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
2.1 Advance local population-based planning, service alignment, integration, and performance improvement						
a) Work with Regional Quality Table on approach for quality improvement and integrated QIPs within sub-regions	In progress	50	In progress	25	In progress	25
b) Develop sub-region health/needs-based analytics including a focus on equity planning	In progress	50	In progress	25	Complete	25
c) Develop investment criteria that support unique requirements of LHIN sub-regions and health equity	In progress	50	In progress	25	Complete	25
d) Define joint vision for integrated health service delivery	In progress	75	Complete	25		
e) Advance a population based funding approach at the LHIN sub-region level	In progress	25	In progress	25	In progress	25
2.2 Advance shared goals with the City of Toronto						
a) Develop a joint Health Accord with the City of Toronto	Complete	100				
2.3 Improve population health and equity in partnership with Toronto Public Health						
a) Develop health equity and population health roadmap to guide sub-regional population-based planning and implementation	In progress	25	In progress	25	In progress	25

How will we measure success?

Taking a Population Health Approach	MLAA	Other Outcome areas of focus
2.1 Advance local population-based planning, service alignment, integration, and performance improvement	- Repeat unscheduled emergency visits within 30 days for mental health conditions - Repeat unscheduled emergency visits within 30 days for substance abuse conditions - Readmission within 30 days for selected HBAM Inpatient Group (HIG) conditions	Number of program/service or HSP integrations
2.2 Advance shared goals with the City of Toronto	Not applicable	Percentage of service requests for Mental Health & Addictions supportive housing resulting in successful placements
2.3 Improve population health and equity in partnership with Toronto Public Health	Not applicable	- Population aged 12 and over who reported being a current smoker - Prevalence of diabetes - Prevalence of hypertension - Suicide rates per 100,000 - Percentage of 18 month well-baby visits completed for children aged 1-2 years old

What are the risks / barriers to successful implementation?

Risk/Barrier	Mitigation
Requires willingness from non-HSP/contracted partners to develop shared vision, goals and performance measures.	The LHIN encourages partnerships between non-HSPs and has reflected population health goals in its performance framework to encourage joint planning. The LHIN will expand invitations to the cross-sector collaborative tables at the sub-region level to include non-health partners and its partners that have an influence over social determinants of health.
Improvement in population health is complex and out of the direct control of any one organization acting alone, a commitment to shared goals for improved outcomes is required across system.	The LHIN is focused on bringing together partners focused on improving population health and leveraging joint capacity.

Integrated Health Service Priorities

Transforming Primary and Community Care

For most patients, community-based care is the optimal place of care and is often less costly than institution-based care. Demand for community-based care is on the rise and, even with increased government spending in this sector, further investments in infrastructure may be required so the healthcare community can effectively respond and meet the demand for its services.

A patient's long-term relationship with their primary health care team is a key cornerstone of high quality care. This relationship has the potential to anchor efforts to drive integration and coordination of the patient journey and as research has indicated, provides better long-term population health outcomes. In order for primary healthcare to make a greater contribution to system integration, the LHIN will build effective networks within each sub-region that actively engages health care providers on an ongoing basis in system design, performance management and consistent quality improvement processes. With a focus on sub-region integration and participation, the relationship between the Toronto Central LHIN and the Primary Care sector is built on a mutually beneficial relationship, leading to better care for residents' within each sub-region.

Transforming primary health and community care means creating conditions that empower patients to get the care they need with ease. The LHIN will invest in strategies that make “every door the right door”, simplifying access and driving integration.

We will focus on building common infrastructure, common spaces, shared services for IT and decision support in order to bring providers together.

Toronto Central LHIN is leveraging new investments from the provincial government to establish innovative models of care that are both patient-centered and cost-effective.

Key enablers to deliver on this Strategic Priority:

- Integrate services and providers around the needs of clients
- Improve access to comprehensive health care through increased number of clients attached to interprofessional primary health care teams
- Improve management of clients with ambulatory care sensitive conditions in the community sector
- Build community capacity to ensure clients can be cared for in the most appropriate place

LHIN Approach to Delivering on this Strategic Priority:

Supporting and leading primary care and community transformation, Toronto Central LHIN will invest in strategies that draw primary care into the broader health care system, simplifying access and driving integration between services in the community.

Strengthening Primary Care

Primary health care is undergoing significant reform in Ontario through a shift to local planning, further integration of primary care into the greater health system and ensuring primary care practitioners are actively engaged in system design and implementation. The intent of these reforms is to create the conditions for a primary care system that continues to improve its ability to manage the health of the population efficiently and effectively.

In this regard, Toronto Central LHIN has performed comprehensive engagement with Primary Care Providers to ascertain key priorities critical to the success of this reform as identified by those in the field. Over the next three years the LHIN will be implementing programs and or strategies in the following regional priorities:

- Attachment, Access and Continuity – Ensure that all residents of the Toronto Central LHIN have access to a primary care provider and are able to receive care in a timely manner;
- Access to Inter-professional Teams – Improve access to inter-professional teams for all patients of primary care providers;
- Access to Specialist Consultations – Improve and streamline access to specialists;
- Discharge Planning – Improve the quality and timelines of discharge summaries and to expand e-Notification around patients who access emergency or impatient care in hospital; and
- Secure Communication – Expand secure communications between providers to expedite follow-up, improve care coordination and reduce duplication of tests. Secure provider/patient communication will also be explored.

The regional priorities are in addition to strengthening local networks that have been recently put into place to actively engage primary care physicians in system planning at a local level.

One Community

The Home and Community Care sector is composed of public and private providers, the majority of which have multiple funders and offer both health and non-health services. This has resulted in many small home and community care agencies that offer similar services and compete for the same funding sources. Patients and their families find it difficult to obtain appropriate services in a timely and coordinated fashion. As a result, patient experience can be fragmented and for some, their full health potential is not realized.

The goal of redesign is to ensure the best outcome for the patient and the system. This includes care pathways that provide the most direct route for getting safe and effective care (patient outcomes) and the most appropriate care (system outcomes).

The Toronto Central LHIN is investing in an Integrated Community Care Strategy that aims to advance a coordinated and integrated approach to community health service delivery that responds to local need of clients and caregivers. The LHIN will develop a roadmap that sets in motion elements of a redesigned community care system that improves access, coordination and navigation for clients and families. This strategy will utilize a collaborative co-design approach that mobilizes the community, involving clients and families, front line staff and primary care.

The LHIN will be working directly with the sub-region community partners to develop concrete action plans to implement elements of the roadmap and foster local sub-region networks of agencies working collaboratively to improve access to care in their respective communities.

Building Community Capacity

System transformation has been focused on improving the patient experience, quality of care and system sustainability by shifting care away from high cost acute care hospitals and into the community and the home. Building the capacity of the community sector is key to ensuring the sector can be an equal partner in a transformed health care system.

The focus will be on building collaboration and realizing efficiencies through investing in common infrastructure and spaces, leadership and professional development opportunities, and shared services for information technology and decision support in the community.

Toronto Central CCAC Utilization by Sub-Region

In Fiscal 2015/2016, Toronto Central CCAC supported approximately 78,000 clients. These clients were broken down as follows (with some clients found in multiple categories):

In-Home Health Care: 65,000
Publicly Funded Schools: 6,000
Private/In-Home Schools: 1,100
Long-Term Care Placement: 12,000

The In-Home Health Care grouping is made up of hospital transitions and homecare clients. The 45,500 homecare clients are distributed across the sub-regions as follows:

Sub-Region	Clients	Percentage
Unknown	1,100	2%
East	9,500	21%
Mid-East	6,500	14%
Mid-West Toronto	11,500	25%
North Toronto	7,800	17%
West Toronto	9,100	20%
Total	45,500	

Goals of this Strategic Priority:

- Increase capacity for services and service integration;
- Develop technology that allows for sharing patient data across sectors and providers;
- Develop common tools and IT infrastructure to support the community;
- Draw on a range of supports outside of the health portfolio;
- Create new models to integrate providers around the needs of patients and neighbourhoods;
- Co-locate services in a way that is meaningful to the local community; and
- Target funding to drive strategic integrations.

Consistency with Government Priorities

Improve primary care capacity and access to specialist care

Toronto Central LHIN continues to advance the implementation of the Primary Care strategy's goals and objectives. Primary and Community Care Committees have been created in all 5 sub-regions and have been meeting to review local population and health system data. Working groups have been established for each of the five strategic priorities – Attachment, Access and Continuity, Access to Interprofessional Teams, Discharge Planning, Access to Specialists and Secure Communications.

Work with providers to further reduce wait times, improve coordination and consistency of home and community care, improve access to speciality care, drive appropriate care utilization starting with people suffering from musculoskeletal (MSK) pain, and those suffering from mood disorders.

Continue to build primary care as the foundation of the health care system and work with health care providers to improve timely access to home and community care input from partners and patients

In partnership with the work already underway to strengthen primary care, the Toronto Central LHIN has launched the Integrated Community Care initiative as part of its strategic plan. Together with community partners, the Toronto Central LHIN is starting to define the foundation of a client-centred, coordinated system that is easy to navigate and access for clients and caregivers with a bold vision that for bringing together Community Support Services, Mental Health and Addictions and Community Care Access Centre services. The team is currently defining a roadmap that will set in motion elements of a redesigned community care system through a collaborative co-design approach together with clients and families, front line staff and primary care.

Continue to implement the initiatives of Patients First: A Roadmap to Strengthen Home and Community Care and support the integration of Health Links into sub-regional planning with input from primary care providers.

Transforming Primary and Community Care: Action Plan

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”	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
3.1 Support a system of integrated primary care						
a) Develop and implement primary care work plans for each LHIN sub-region	In progress	50		50		
b) Implement LHIN-wide Primary Care Strategy, including: • Attachment, Access and Continuity • Access to Interprofessional Teams • Access to Specialist Consultations • Hospital Discharge Planning • Secure Communication	In progress	50	In progress	25	Complete	25
c) Align Health Links within primary care model	Complete	100				
3.2 Design, implement, and evaluate a model of integrated care for home and community based care (home care, CSS, CMH&A)						
a) Consult with broader home and community care, community support services and community mental health and addiction sectors to bring recommendations how to implement the core deliverables of the One Community plan	Complete	100				
b) Develop policy for community hubs in alignment with provincial approach and Toronto Central LHIN	Complete	100				

integrated population-based service delivery model as well as health equity framework						
c) Improve MLAA performance for community indicators (nursing and personal support access measures)	In progress	75	Complete	25		
d) Finalize structure and develop work plans for resource capacity organizations aligned with primary care objectives	Complete	100				
e) Implement Home and Community Care Roadmap	In progress	75	Complete	25		
f) Form sub-region community networks with the responsibility for access, coordination and navigation	Not yet started	50	Complete	50		
g) Institute a centralized access process to ensure resources are coordinated regionally and deployed locally.	Not yet started	50	Complete	50		
h) Establish and confirming common protocols to improve capacity and flow, assessment, referral and information sharing	Not yet started	50	Complete	50		
i) Incorporate a clear care coordination and navigation framework that will support patients with multiple needs.	Not yet started	50	Complete	50		
j) Establish LHIN-wide standards and a common basket of services, common tools and information sharing	Not yet started	50	Complete	50		
3.3 Complete joint planning with CCAC to deliver on provincial direction for home care						
a) Create joint planning partnership with Toronto Central CCAC for coordination and functional alignment in LHIN sub-regions	Complete	100				

How will we measure success?

Transforming Primary Health and community Care	MLAA	Other Outcome areas of focus
3.1 Support a system of integrated primary care	• Physician follow up within 7 days of discharge** • Hospitalization rate for ambulatory care sensitive conditions • 90th percentile Emergency Department length of stay for Minor/Uncomplicated Patients	• Percentage of adults who have a primary care provider • Percentage of adults who are able to access their primary care provider the same day / next day when they are sick • Percentage of Complex Patients (4+ chronic conditions) with Coordinated Care Plans – currently only numerator available; volumes reported
3.2 Design, implement, and evaluate a model of integrated care for home and community based care (home care, CSS, CMH&A)	• Percentage of home care clients with complex needs who received their personal support service visit within 5 days of date they were authorized for service • Percentage of home care clients who received their nursing visit within 5 days of date they were authorized for service • 90th percentile wait time from community for CCAC in-home services (excluding case management)*	
3.3 Complete joint planning with CCAC to deliver on provincial direction for home care)	• Percentage of home care clients with complex needs who received their personal support service visit within 5 days of date they were authorized for service • Percentage of home care clients who received their nursing visit within 5 days of date they were authorized for service	

What are the risks / barriers to successful implementation?

Risk/Barrier	Mitigation
Requires strong partnerships with Physicians and primary care partners	The LHIN is focused on strengthening partnerships within primary care by leveraging and engaging leaders across the system. The LHIN is establishing Primary Care leads to facilitate the growth of these relationships.
Requires ability to engage solo practice physicians to establish strong primary care networks without funding levers	
Requires integration or very strong coordination across a number of community agencies to establish an integrated approach to community service delivery	The LHIN is developing an approach to integration which is informed by community providers and agencies. The LHIN has identified a need to create enhanced care coordination / navigation that is systems-based and focused on patient need. The LHIN will build on current sector-based resources to achieve a system-vision.

Integrated Health Service Priorities

Achieving Excellence in Operations

To achieve this strategic plan, Toronto Central LHIN will need to strengthen its own capacity. Over the last nine years, the LHIN model has matured, evolving over time from simply carrying out the management of contracts for the provision of health care services, to an organization that is leading data-driven planning for the populations we serve.

The new LHIN will build on the successes and strengths of both the Toronto Central LHIN and Toronto Central CCAC and bring together healthcare system planning and direct client service delivery. This will lead to a new opportunity to leverage improved service coordination among multiple providers while continuing to deliver high quality and integrated home and community care. Advancing the mandate for the LHIN will be possible through leveraging the synergies between both organizations and building on the excellent work already underway.

From an operational service delivery perspective, the organization will continue to stabilize the integrated team model, evaluate it and leverage lessons learned. The implementation of a complex complaints program, as well strengthening Client Services delivery through development of standard tools, templates and processes, are planned for early 2017/2018. There will also be a concerted effort to drive information management/information technology priorities such as enabling mobile equipment connectivity, optimizing supplies-ordering and decommissioning of artefact infrastructure. In addition, there is an intended launch of refreshed documentation standards and as an intended move to a new documentation methodology.

From a system transformation perspective, the organization will continue to drive provincial priorities including advancing the Levels of Care framework, implementing Personal Support Worker rate harmonization, service provider organization realignment to LHIN sub-regions, and continuing engagement and co-design activities with clients and families to ensure a patient-centered system.

Toronto Central LHIN has a proven track record of leveraging emerging technology and building analytic capacity to carry out effective planning. We believe there are further opportunities to strengthen our role and effectiveness in the system. There are a number of specific areas that we intend to focus on over the next four years to improve our overall performance. To effectively manage the health care system we will need to invest in the following areas:

- **Enhanced data and analytics** - In the current fiscal environment, making informed decisions about investments is more important than ever. We know that ready-access to comprehensive data is essential to effectively managing the healthcare system, but this is one area where the system has fallen behind. To improve access to information and to facilitate integration, Toronto Central LHIN will support the identification of IT solutions that can be leveraged across the system.

- Evaluation methodologies - We need to properly assess our work, so we can maximize our investments and make informed decisions.
- Community engagement activities with priority and at-risk populations - We need to understand individual needs and challenges so we can tailor solutions and facilitate access to appropriate care.
- Policy and strategy frameworks - These will be developed to create consistency and clarity of purpose to guide decision-making for managing growth, implementing funding reform, brokering service changes and driving strategic integration.
- Cross-sectoral partnerships - Adopting a population health approach requires us to work with a number of health and non-health partners so we can maximize our effectiveness and reach.

Goals of this Strategic Priority:

- Facilitate integration and partnerships via shared tools and projects.
- Build the core competencies of the Toronto Central LHIN.
- Initiate public reporting of performance metrics to drive provider excellence in care delivery.
- Build leadership capacity to support change management in the system.
- Develop policy frameworks to guide health equity and community engagement activities.

Key enablers to deliver on this strategic priority:

- Leverage partnerships to expand capacity for system transformation
- Increase staff capacity to support change management activities
- Develop policy frameworks (e.g. health equity, community engagement)
- Further integrate evidence and data analysis across all service planning and decision making

Consistency with Government Priorities

Achieving health system performance including the success of transformational activities

In alignment with the Toronto Central LHIN's strategic plan goals and priorities, a Strategic Plan Performance framework has been developed consisting of Toronto Central LHIN strategic plan measures and operational performance measures. Early results include baseline relationship between the measures and objectives of the Toronto Central LHIN strategy and organizational work plan.

Toronto Central LHIN will continue to work closely with the Ministry to develop performance targets to measure the success of transformational activities and publicly report on progress and outcomes

Moving forward, the Toronto Central LHIN will continue to be accountable for outcomes and report on our progress toward achieving health system performance targets. In doing so we will continually review and re-assess indicators, and establish applicable targets to ensure the framework is meaningful and relevant.

Effectively manage all operational, strategic, and financial risks encountered by the LHINs while ensuring alignment with government priorities and achievement of business objectives.

Champion Ontario as a leading ecosystem to adopt and scale new and innovative health technologies and value-based processes

In support of the ministry's Digital health Strategy, Toronto Central LHIN will:

Ensure that any Hospital Information System (HIS) renewal decisions are consistent with HIS Renewal Advisory Panel clustering recommendations and reflect a commitment to reduce the overall number of HIS instances

Support the delivery of digital solutions to improve patient access and navigation and referrals to specialists, capitalizing on opportunities to implement or expand existing virtual models of care or digital self-care or expand to online consultation between primary care providers and specialists that are consistent with existing provincial initiatives.

ACHIEVING EXCELLENCE IN OPERATIONS: ACTION PLAN

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”	2017/18		2018/19		2019/20		
	Status	%	Status	%	Status	%	
4.1 Develop, implement and evaluate a system of performance measurement and management							
a) Improve performance of MLAA indicators	In progress	50	In progress	25	Complete	25	
b) Operationalize a performance measurement framework for strategic goals, priorities and organizational performance	In progress	50	In progress	30	Complete	20	
c) Collaborate with LHINs to develop pan-LHIN performance management framework	Complete	50	In progress	30	Complete	20	
d) Respond to the Provincial Auditor General Report on LHINs	Complete	100					
4.2 Expand excellence in communications and engagement							
a) Review and update LHIN internal and external communications plan	Complete	100					
b) Develop citizen-focused strategy and tools to expand LHIN understanding	In progress	75	Complete	25			
c) Launch new website and intranet for integrated organization	In progress	75	Complete	25			
d) Develop an optimistic and compelling vision for transition	Complete	100					
e) Develop and support the senior management team in the creation of a speaker's bureau	In progress	75	Complete	25			

4.3 Combine system oversight with service delivery and service management							
a) Create integrated performance monitoring plan with CCAC/LHIN reporting tools	In progress	75	Complete	25			
b) Integrate operational planning and decision funding allocations processes	In progress	75	Complete	25			
c) Integrate operations of CCAC/LHIN	In progress	75	Complete	25			
4.4 Improve HSP organizational efficiency and effectiveness							
a) Develop funding and project management tool for LHIN discretionary funding	In progress	50	In progress	25			25
b) Identify opportunities for shared services in community sector	In progress	50	In progress	25			25
c) Implement solution to deliver full view of the patient journey across community, primary care and hospital to support improved planning analysis and evaluations	In progress	50	In progress	25	Complete		25
d) Enhance HSP 360 to align to Toronto Central LHIN strategy and performance needs (incl. LHIN sub-regions)	In progress	50	In progress	25	Complete		25
4.5 Successfully complete seamless integration of CCAC and LHIN organizations							
a) Complete all “must have” items required pre T-Day for Transition and implement local initiatives for achieving readiness	In progress	100					
b) Implement pre T-Day Pan-LHIN and Ministry requirements for achieving readiness	In progress	100					
c) Implement post T-day initiatives for integration of the LHIN and CCAC required to function as one organization	Planned to begin in early 2017/18	100					

How will we measure success?

Achieving Excellence in Operations	MLAA	Other Outcome areas of focus
4.1 Develop, implement and evaluate a model for performance measurement and management	Not applicable	Health service provider performance against select Accountability Agreement performance measures
4.2 Expand excellence in communications and engagement	Not applicable	Toronto Central LHIN performance rating by health service providers and partners
4.3 Combine system oversight with service delivery and service management	Not applicable	Health service provider performance against select Accountability Agreement performance measures
4.4 Improve HSP organizational efficiency and effectiveness	Not Applicable	- HSP performance against selected performance measures - Hospital Total Margin - Community Balanced Budget - Financial Current Ratio
4.5 Successfully complete seamless integration of CCAC and LHIN organizations	Not applicable	Success in this work stream would be determined by achieving key deliverables or objectives related to the integration of LHIN and CCAC.

What are the risks / barriers to successful implementation?

Risk/Barrier	Mitigation
Requires change management internally and externally should there be any legislation or policy changes.	Change management plans will be put in place as necessary.
Requires participation by HSPs and system partners in system improvements.	The LHIN is cross-sector partnerships and planning tables that enable ongoing participation with HSPs and system partners focused on improvements.
Requires engagement and partnership with physicians in a difficult in an environment where physicians have been unsuccessful in negotiating their contract.	In 2016, the LHIN appointed a Primary Care Physician Advisor and recruited Physician Leads for each of the 5 sub-regions to champion and engage physicians and other providers on the planning and implementation of initiatives to improve primary care across the LHIN sub-region.

Integrated Health Service Priorities

Leading and Supporting Our People

The CCAC and the LHIN will maintain a dedicated focus on leading and supporting people as the organization's primary asset.

Goals of this Strategic Priority:

- To support our people to deliver outstanding care to every person, every day and ensure staff are set up for success and are celebrated and inspired.

Transition will bring together two different organizations and two organizational cultures. Thoughtful and active management to create a new shared culture and values from the legacy of both organizations will be critical to stability, smooth transition and continued high performance for the future.

These activities will be supported by increased leadership presence and initiatives that foster team and relationship-building at all levels in the transformed organization (i.e., Board of Directors, LHIN Executive Team, etc.). A particular emphasis during transition will be placed on ensuring that staff continue to be supported in providing efficient, effective and high quality of care to clients.

Key activities under the "People Plan" will continue to include implementation and expansion of coaching and resiliency training to all staff; continued advancement of a "You Matter" campaign to recognize and celebrate staff contributions; and there will be a focus on optimization, expansion and evaluation of internal integration of Client Services teams by aligning team assistants to population-based programs.

There are several such initiatives designed to improve efficiency and to release time to care or lead. These initiatives leverage technology to increase connectivity to care coordinators and Resident Assessment Instrument and Client Health and Related Information System refreshes. Extensive work is underway to streamline and combine organizational policies and documentation standards, supplemented with the rollout of competency-based training for all care coordinators and other clinical staff.

Key enablers to deliver on this strategic priority:

- Leverage existing expertise from our combined our human resource and organizational development departments to continue to support staff to deliver high quality care
- Continue to develop opportunities for staff recognition
- Further integrate teams across departments to foster growth and expand opportunities
- Build on our organizations strong commitment to supporting and collaborating with staff

Consistency with Government Priorities

While transition of the CCAC is important for the implementation of the Patients First Act, the opportunities within transformation are truly paramount and dependent upon our collective workforce's abilities and achievements. By focusing on fostering a high performing team that is both able to plan, fund and integrate health services locally, as well as the coordination and delivery of home care services we are positioning ourselves to deliver on the **key priorities** as they were outlined in the Minister's Mandate letter:

- **Improve the patient experience by putting the patient voice at the centre of health care planning and by delivering care that is responsive to patients' needs, values and preferences.**
- **Address the root causes of health inequities by strengthening the social determinants of health, investing in health promotion, and reducing the burden of disease and chronic illness.**
- **Create healthy communities by improving access to primary care and reducing wait times for specialist care, mental health & addictions services, home and community care and acute care for patients when they need it, which will reduce variation in access across the province.**
- **Break down the silos between our health care sectors and providers to ensure seamless transitions for patients, and to ensure that providers work together to provide patient centred care.**

LEADING AND SUPPORTING OUR PEOPLE: ACTION PLAN

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”	2017/18		2018/19		2019/20		
	Status	%	Status	%	Status	%	
5.1 Establishing a shared-culture for the new organization							
a) Establish a joint Senior Management Team	Complete	100					
b) Joint visioning work with staff and managers via focus groups and facilitated engagement	In progress	75	Complete	25			
c) Create a new compelling vision for new organization and establish shared values for the new organization	In progress	75	Complete	25			
5.2 Ensure efficient and effective provision of service and quality of care to clients							
a) CCAC education session on governance for LHIN Board of Directors	Complete	100					
b) Establish Service Continuity Plan as part of transition readiness	In progress	75	Complete	25			
c) LHIN Board to establish Quality Committee	In progress	25	Complete	75			
5.3 Staff Development							
a) Coaching and Resiliency training for all CCAC and LHIN staff	Complete	100					
b) Optimize and evaluate Client Services Integration model	Not yet started	50	Not yet started	50			
5.4 Improve infrastructure support for optimal performance							
a) Establish Joint CCAC-LHIN Policy Framework	Complete	100					
b) Develop fully integrated set of policies and procedures for new organization	In progress	75	Complete	25			

c) Establish new documentation standards framework and supporting tools and processes	In progress	25	In process	50	Complete	25
d) Rollout of competency-based training for all care coordinators	In progress	25	In progress	50	In progress	25
e) Refresh CHRIS and RAI infrastructure	In progress	100				

How will we measure success?

Achieving Excellence in Operations	MLAA	Other Outcome areas of focus
Staff and leaders remain mission and values focused – help people to focus on what’s most important for clients and families	Not applicable	Staff turnover rates and results of employer engagement survey
Reducing staff turnover - ensure stability of staffing	Not applicable	Staff turnover rates in administration and direct service delivery
Ensure stability and continuity of Client Services and maintain excellence in operations	Not applicable	Monitor key indicators related provision of home care services

Risk/Barrier	Mitigation
Requires willingness and buy-in from staff in the new LHIN to create a new shared culture and values from the legacy of both organizations	The LHIN has actively sought to ensure that senior management is engaged and bought into the strategy and is aware of the legacy cultures of both organizations. Through communications and a thoughtful and active management approach staff will be engaged in the new vision and values. Regular senior management meetings reviewing the progress of the strategy and the implementation and spread of new values will be critical to developing a positive new shared culture. Additional support will be provided from third party consultant who have been engaged to provide

	guidance and best practice to address specific needs of staff through change and transformation.
Rollout of the optimized Client Services Integration model is not successful.	Leverage the lessons learned from the initial Client Services Integration Model adoption to understand the opportunities to improve the rollout of successive phases. Utilize a rapid quality improvement cycle approach for implementation and evaluation to be able to course-correct throughout the year.
Refresh CHRIS and RAI infrastructure does not rollout effectively	Working closely with HSSO and other IT partners with regular check-ins and project controls in place to ensure the implementation and rollout is conducted according to plan and delays or barriers are identified early-on to avoid delays and mitigate any barriers/risks that arise.

LHIN Operations Spending Plan

LHIN Operations- DRAFT Sub Category (\$)	2016/17 Planned Expenses	2017/18 Planned Expenses	2018/19 Planned Expenses	2019/20 Planned Expenses
Salaries and wages	5,214,320	5,537,269	5,537,269	5,537,269
Employee Benefits				
HOOPP	373,427	384,054	384,054	384,054
Other Benefits	747,651	834,145	834,145	834,145
Total Employee Benefits	1,121,078	1,218,199	1,218,199	1,218,199
Transportation and Communication				
Staff Travel	26,800	26,800	26,800	26,800
Governance Travel	4,500	4,500	4,500	4,500
Communications	62,200	62,200	62,200	62,200
Other T & C	31,400	31,400	31,400	31,400
Total Transportation and Communication	124,900	124,900	124,900	124,900
Services	-			
Accommodation	521,831	747,639	776,045	786,388
Community Engagement	568,713	568,713	578,713	578,713
Consulting Fees	275,000	275,000	275,000	275,000
Equipment Rentals	6,095	6,095	6,095	6,095
Governance per Diems	77,500	77,500	77,500	77,500
Shared Services	473,500	-	-	-
Other Meeting Expenses	25,000	25,000	25,000	25,000
Other Governance Costs	18,000	18,000	18,000	18,000
Printing and Translation	87,000	87,000	77,000	77,000
Staff Development	94,500	94,500	94,500	94,500
Total Services	2,147,139	1,899,447	1,927,853	1,938,196
IT Equipment	29,305	29,305	29,305	29,305
Office Supplies and Purchased Equipment	23,800	23,800	23,800	23,800
Total Supplies and Equipment	53,105	53,105	53,105	53,105
LHIN Operations: Total Planned Expenses	8,660,542	8,832,920	8,861,326	8,871,669
CCAC Expenses	-	264,303,000	272,232,090	280,399,053
Total TC LHIN and CCAC Expenses	8,660,542	273,135,920	281,093,416	289,270,722

Note 1: Shared service expenses (LHIN-Collaborative and LHIN Shared Services Ontario) are not included in the planned expenses for 2017/18, 18/19 and 19/20 due to their transition to Health Shared Services Ontario.

LHIN Staffing Plan (Full-Time Equivalent)

Position	2016/17 Actuals as of Mar 31 2016 FTEs	2017/18 Forecast FTEs	2018/19 Forecast FTEs	2019/20 Forecast FTEs
Administrative Assistant	3	4	4	4
Accounting Manager/SR Finance Advisor/ Sr.	1	1	1	1
CEO	1	1	1	1
Communications Manager	1	1	1	1
Communications Assistant/Coordinator	1	1	1	1
Community Eng and Communications Consultant	3	3	3	3
Consultant	4	4	4	4
Corporate Coordinator	1	1	1	1
Directors	2	22	22	22
Executive Assistant	1	1	1	1
Executive Lead- Transition and Project Mgt Office	-	1	-	-
Finance Lead/Controller	1	1	1	1
Financial Coordinator	1	1	1	1
French Language Services Coordinator	1	1	1	1
HR Business Partner	-	1	1	1
Office Coordinator	1	1	1	1
Pan Am Games Emer Lead Planner	1	-	-	-
Performance Measurement Analyst	1	1	1	1
Planner	2	2	2	2
Policy Advisor	2	2	2	2
Project Manager	2	2	2	2
Receptionist	1	1	1	1
Senior Business Analyst	1	1	1	1
Senior Directors	4	-	-	-
Sr. Consultant	2	2	2	2
Sr. Financial Analyst	4	4	4	4
Sr. Perf/Cont/Alloc Consultant	6	5	5	5
Sr Planner	2	2	2	2
VP	-	5	5	5
LHIN Operations: Total FTEs	50	72	71	71
CCAC FTEs (excluding Executives and Directors)	-	638	638	638
Total TC LHIN and CCAC FTEs	50	710	709	709

In 2017/18, the total expected FTEs transfer from CCAC is 669 and this includes staff on maternity/extended leave.

To date, the decision around VP Clinical is not yet finalized, thus not included above. The VP of Home and Community Care is included in the VP line

Communications Plan

Business Objectives

The Annual Business Plan (ABP) is a document essential to the work of 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 outlined in the IHSP 2016-2019.*
- 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 Toronto Central LHIN will develop a regional system of integrated healthcare across the care continuum, from primary care and public health through to community, acute and long-term care.

Communications Objectives

1. To raise awareness with the public and health service providers about what the LHIN is doing to improve local health care service and delivery toward a healthier Toronto.
2. Create awareness of specific actions and accountabilities for each stakeholder to ensure successful implementation of TC LHIN's 2015-2018 Strategic Plan.
3. Proactive and timely communications to the public, including patients and caregivers, that have clarity of purpose and are customized based on audience.
4. Preserve open communication throughout transition and transformation and provide a clear and positive vision of the new organization for the future that is communicated to clients, employees, partners and stakeholders, with no negative impact to client service delivery.
5. Raise awareness of health care services available in the region and provided by the LHIN, access to health care services and system navigation.

Context

The Toronto Central LHIN's Strategic Plan identifies actions to be taken to improve our uniquely urban health care system and respond to the changing needs of the people served in our LHIN. 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.

Target Audiences

The Toronto Central LHIN communicates with many audiences, all of which have various levels of interaction with and understanding of. We tailor our communication efforts for each audience, and we aim to establish mechanisms for two-way dialogue.

Audience	Internal Audiences	External Audiences
Primary – <i>these are the audiences that have a direct stake in our work.</i>	• Board of Directors • Senior Management Team • Staff • Home and Community Care portfolio • Physician Advisors	• Patients/Clients, Caregivers and Family Members • Ministry of Health and Long-Term Care • Toronto Central Providers: ○ Health Service Providers ○ Mental Health and Addictions Agencies ○ Home and Community Care Service Provider Organizations ○ Community Health Centres ○ Community Support Services ○ Hospitals ○ Long-term Care Homes
Secondary – <i>these are the audiences who have an interest in our work.</i>	• Advisory Groups • Toronto Indigenous Health Advisory Circle • French Language Services • Mental Health and Addictions • Children and Youth • Health Professional Advisory Committee • Strategic Advisory Council • Integrated Health System Emergency Response • Citizens' Panel	• Public (all residents of Toronto Central LHIN and those who access services within its boundaries), which includes both the general public and the informed public. • Media • Members of the Provincial Parliament (MPPs) • Public Health Units • Other funders • Other community agencies • Police • Toronto Community Housing • United Way • Toronto Public Health • Primary Care Providers

Audience	Internal Audiences	External Audiences
		• Health Shared Services Ontario • Other Ontario Local Health Integrated Networks • Provincial Associations including Unions • Provincial Agencies such as Health Quality Ontario

Key Messages

Toronto Central LHIN

- Over the last five years, Toronto Central LHIN has made significant progress toward improving the health care for our residents and we are well positioned to continue to support health system transformation in the future.
 - We have developed strong relationships outside of health care and are looking at the broader factors that impact people's health.
 - We are ensuring the system is reliable for many years to come by actively supporting the integration of services to reduce cost and increase efficiency.
 - We have created innovative tools and started to gather data to help us better understand the unique needs within our communities.
- As the health system continues to shifts focus toward more patient-centered care, Toronto Central LHIN will remain accountable to our residents and ensure that the system is able to meet the needs of all those who access care in the Toronto Central LHIN.
- Toronto Central LHIN will support a system that is coordinated, inclusive and provides timely access to high quality health care so that everyone has a fair chance to lead a healthy life.
- While maintaining our core business of funding, performance management, planning, and design, Toronto Central LHIN will be guided by three overarching goals:
 - **A Healthier Toronto** aims to improve the overall health of everyone in our city and to find new ways to reach those who do not regularly access health services. We will seek out community-driven solutions to address barriers in care.
 - **Positive Patient Experiences** will include the perspective of the patient and their caregivers, while driving system changes that will result in care that is cost-efficient, of high quality, and easy to navigate.
 - **Innovation & System Sustainability** will involve applying innovations to help us respond to fiscal restraints and by maximizing value from our health care investments.

- Our sights are set firmly on these goals and to achieve them the Toronto Central LHIN will work to deliver the following priorities.
 - Designing Health Care with Citizens
 - *We will relentlessly pursue every option to deliver what is most important to citizens in their health care*
 - Taking a Population Health Approach
 - *We will harness local perspectives and collaborate to support people to live the fullest and healthiest lives possible*
 - Transforming Primary Health and Community Care
 - *We will drive the highest possible care integration*
 - Achieving Excellence in Operations
 - *We will focus on innovative solutions, teamwork and leadership to advance a health care system that puts patients first*
 - Leading and Supporting our People
 - *We will support the full potential of all members of our team*

- We will be relentless in our efforts to ensure that our community's voice is reflected in the work we do and we will continue to engage our communities to ensure our strategies and initiatives are grounded in and guided by what matters most to the individuals, families and communities we serve.

- Anchored in enhanced accountability for LHINs and a more patient-centred system, the structural changes proposed in *Patients First* would see LHINs assume responsibility for home and community care and system integration, have greater involvement with primary care, and improved linkages with population and public health planning. We believe these changes would allow us to work with new partners and in new ways to improve the local health care system.

Patients First

- The *Patients First: Action Plan for Health Care* is Ontario's plan to transform the health care system into one that puts the needs of patients at its centre.
- The *Patients First: Action Plan for Health Care* sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre of our health care system by improving the health care experience: increasing access, connecting services, informing patients and protecting our health care system.
 - We have made progress in all four priority areas, but we can do more to put patients first.
- By putting patients first in everything we do, we will provide faster access to the care patients need today and make the necessary investments to ensure our health system will be there for patients for generations to come.

- On December 7, 2016, Ontario passed the *Patients First Act, 2016*, an important step forward in the *Patients First: Action Plan for Health Care*.
- Once fully implemented, changes supported by the Patients First Act will make local health care more responsive to local needs:
 - Patients will benefit from improved access to primary care, including a single number to call when they need health information or advice on where to find a new family doctor or nurse practitioner.
 - Primary care providers, inter-professional health care teams, hospitals, public health units and home and community care providers will be better able to communicate and share information, to ensure a smoother patient experience and transitions. Our goal is that patients will only have to tell their story once.
 - Administration of the health care system will be streamlined and reduced, with savings put back into improving patient care.
 - The voices of patients and families in their own health care planning will be strengthened.
 - There will be an increased focus on cultural sensitivity and the delivery of health care services to Indigenous peoples and French speaking people in Ontario.
- The Act expands the mandate of LHINs to include home care, primary care, and public health, and strengthens LHIN responsibilities in planning, health equity and engagement with patients, families and Indigenous and French-language health care partners.
- LHINs will ensure that any changes are seamless and that they simplify and improve patient experience. There will be no added bureaucracy and financial savings will go to patient care.
- Trust and transparency are Key principles of the transition and we will create a new organization that builds on the successes and strengths of both Toronto Central CCAC and LHIN, aligned with the vision of Patients First.
- New LHIN organization that continues to deliver high quality and integrated home and community care within an integrated health care system that brings together health care system planning and direct client service delivery - leading to a new opportunity to leverage improved service coordination among multiple providers.
- We are embarking on an important journey together and by remaining centred by our common goal of improving access to health care for patients and their families, we are supporting a more integrated and responsive health care system.

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 Toronto. Toronto Central 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.
- Proactively raise awareness of health care services available in the region and support system navigation working with partners where appropriate.

Additionally, Toronto Central LHIN's communications initiatives will support the Ontario government's Patient's First: Action Plan for Health Care (February 2015). Specifically, LHINs have a responsibility in important provincial initiatives such as Health System Funding Reform, Health Links and the health initiatives for seniors. 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. Toronto Central LHIN uses a number of quality communication and community engagement tools to communicate, including:

- *Annual Report*
- *Report to the Community*
- *CEO Reports to the Board*
- *Toronto Central LHIN CEO visiting individually with each of our health service providers and service provider organizations*
- *Proactive and responsive news releases*
- *Proactive and Reactive Media relations and outreach*
- *eNewsletters*
- *Internal Newsletters*
- *Stakeholder eblasts*
- *Local Collaboratives*
- *Community engagement reports*
- *Social media*
- *Webinars*
- *CEO Blogs (Internal and External)*
- *Program based brochure*
- *Presentations and speaking engagements*
- *Regular website updates and ensuring its content is relevant for and accessible to our audiences*
- *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 Toronto Central LHIN's communications efforts will be conducted in-house. The evaluation will include the following measures:

Tracking and content analysis (negative, neutral or positive) of 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.
- Tracking of social media metrics (new followers, number of impressions and engagements on Twitter and number of views on YouTube videos). Content analysis of tweets and comments on YouTube to hear directly what people are saying about us and local health care.
- Tracking and analyzing readership metrics of CEO Blogs, Newsletters and other communication materials.
- Patient complaints – since we are working on improving awareness of the LHIN's work to improve local health care, tracking what we hear directly from patients, clients and families about us and the local health care is extremely important.
- 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. As activities are carried out, Toronto Central LHIN has the ability to make quick modifications based on shifts and lessons learned.

Community Engagement Plan

Community Engagement in the Toronto Central LHIN

Section 16.2 of the LHSIA outlines the LHIN's legislative mandate to engage communities in health-system planning on an ongoing basis. The Pan-LHIN definition of community engagement is the meaningful involvement of LHIN and HSP stakeholders in activities ranging from priority setting and planning to decision-making, implementation, review and evaluation. Toronto is one of the most diverse cities in the world. Ensuring that health services meet the needs of the population, in the most equitable way, is a core mandate for the Toronto LHIN.

Service users and the people that live in the communities we serve are experts in how they experience an illness, a set of life circumstances, the care they receive or the health system with which they interact. In recent years, community engagement has gained prominence as a critical element of health system planning and decision-making. Good community engagement helps us design health services that are responsive to the needs of our population, and it gives those we serve the opportunity to participate and to be active partners in the decision-making process.

Often, in health planning we consider the needs of those actively receiving care; and fail to give a voice to those who need services but are not connected to them. The LHIN is uniquely positioned to work at both the patient and community level to identify unmet needs and local priorities and recommendations.

Our 2015-2018 Strategic Plan presents a vision of a health care system that wraps around the patient, is more responsive, cost-efficient, of higher-quality, and easier to navigate. Engaging patients and their families in the design of the health care system will ultimately ensure that the system is more effective in improving patient outcomes.

Toronto Central LHIN Citizens' Panel

The Toronto Central LHIN launched its Citizens' Panel in 2016. The purpose of the Panel is to collaborate with the citizens of our LHIN - the patients, caregivers, families, and residents at the centre of our health care system - to find ways to improve their experience in the system, and ultimately their health outcomes.

In our first year the Toronto Central LHIN:

- Created a panel with eighteen diverse members that span representation from the geography and the various populations that we serve

- Held seven Citizens' Panel meetings where the members used their combined experience, values and priorities to inform the work of Toronto Central LHIN to better align our planning and strategy with the perspective of the residents, patients, family members, clients and caregivers we serve
- Agenda's Topics included: priority-setting and selection of meaningful themes projects; Overview of patient relations process; Consultation of Patients First Act (pre and post implementation);
- Accomplishments: Terms of Reference, Engagement Guidelines, draft workplan, priority-setting, consultations on the LHIN Population Health Strategy and on Patients First Act

The LHIN is also expanding our reach to engage with a diverse set of health care providers, patient/caregiver and resident communities - including Indigenous, Francophone, and ethno-cultural sub-populations. Our goal is to understand the needs and priorities of those we are designing the health system for and to make decisions that are informed by their perspective.

Toronto Central LHIN engages with six types of groups: the public; health service providers; health professionals/workers; strategic partners; government, elected officials and interest groups; and priority communities.

The goal is to foster collaborative relationships with patients and families and to enable their full partnership with clinicians and administrators in the design and improvement of our health care system.

Patients should experience a system that is:

- seamless and cross-sector/facility transitions are barrier-free;
- culturally appropriate and culturally competent;
- supportive of open and effective communication between patient and provider, as well as across providers; and
- inclusive of family, caregivers – across all generations.

Taking a population health approach requires that services are reflective and are proportionate to need. Hearing from patients, caregivers and residents about their experience interacting with the health care system, their analysis of gaps and opportunities, and their ideas for strengthening local health care, will continue to drive our population health approach and allow us to focus our efforts in the right places and on the right issues.

With this expanded view of whom we are planning for, we have the opportunity to begin to examine the disparities in health that we see across the population and among the groups that are represented within it. We know that there are particular groups who face challenges accessing the services they need, including newcomers, our Indigenous population, and our lesbian, gay, bisexual, or transgender community. Improving the overall health of Torontonians requires a better understanding of the unique needs of these sub populations within and solutions to improve health equity.

Addressing these needs is a multi-step process. We must be able to identify variations through a robust analysis of population health data. Then there is an important process of engaging with communities to understand their needs and to design tailored solutions together in order to ensure that we are able to be effective.

Elements of Our 2017/2018 Community Engagement Plan

Our 2017/2018 community engagement plan will continue to draw from the following five main elements identified in our 2016/2017 plan with some refinements made:

- 1) Toronto Central LHIN Citizens' Panel and Citizen Advisors Program
- 2) Local Geographic Level Engagement
- 3) Population-based Targeted Engagements
- 4) Broad Dissemination of Information
- 5) Knowledge Exchange and Capacity Building

These elements have been refined to form our approach to our 2017/2018 community engagement plan whereby three areas of focus and three supporting strategies have been identified. The objective of our 2017/2018 Community Engagement plan is to build capacity and strengthen the citizen voice. The supporting strategies of this objective is as follows:

- 1) Broad Dissemination of Information
- 2) Knowledge Exchange
- 3) Capacity Building

These strategies will inform the advancement of the following three areas of focus:

- i) Strengthening our Toronto Central LHIN Citizens' Panel
 - Our 2017-2018 Community Engagement plan will work to advance the work of the citizens' panel and strengthen its capacity by building a curriculum to augment the skills and knowledge of the group and to ultimately enable continued meaningful participation.
- ii) Expanding our community engagements at the local-geographic level to involve members of our community in our sub-region work
 - As we move towards a sub-regional approach, a clear understanding of the unique, local context of each of our five LHIN sub-regions will be critical to our success. Our 2017/2018 Community Engagement plan will be dependent on integrating the citizen's voice with our population health approach to planning and delivery of local health care.
- iii) Population-based targeted engagements will be conducted to advance our sub-region work and to assist in identifying sub-region priorities by validating both the needs of the community and the proposed interventions

- Bridge/leverage off of existing community engagement programs with partners and health service providers to facilitate continued refinement of sub-region priority-setting

Our approach will continue to be guided by the principle of inclusive engagement, where deliberate and focused efforts are made to reach further into communities and remove barriers for groups who face obstacles.

Key to our 2017/2018 Community Engagement plan is the commitment to advance our communication pathways with members of our community and to provide feedback and follow-up on all our engagement activities. Strengthening our existing feedback process and extending them to support the upcoming activities of 2017/2018 will ensure meaningful engagement.

The following table expands on the LHIN's 2017/2018 Community Engagement Strategy by highlighting how we will engage with a variety of HSPs.

Community/ Stakeholder	Initiatives
Health Service Providers	Moving toward smaller geographic regions for the planning, delivery and evaluation of health care services presents new opportunities to engage with health service providers where they provide services. This includes engagement within Local Collaboratives at sub-region levels and Service Provider Organizations to inform population-based planning and collaboration. • Toronto Central LHIN HSP Board-to-Board sessions to inform/involve HSP Boards in transformation initiatives including Health Links, e.g., community sector capacity building; clinical service integrations. • Smaller working group sessions with sub-region leads to focused on tackling key initiatives • Tailored information and updates for HSPs and SPOs through webinars
Health Professionals	Primary care engagement The LHIN has created an environment to actively engage with primary care providers within each of the sub-regions. A primary care clinical lead (a recognized physician leader) has been provided within each local sub-region to build a committee that represents the various primary care models in each area. These committees will provide critical insight into the needs of the sector and further provide advice on implementation strategies to attain optimal outcomes. The committees include representatives from the community sector, hospital representatives and

	the CCAC to ensure that issues and solutions identified take into account an integrated approach in the process. It is through these committees, implementation of priority projects and engagement directly by local Primary Care Clinical Leads with local physicians that Toronto Central LHIN will be able to ensure active participation by family physicians. A strongly engaged, integrated primary care sector translates to better population health outcomes.
Public, patients, clients, caregivers	Broad Dissemination of Information This year we will increase the information flow to our stakeholders. Our goal is to provide a broad range of Toronto Central LHIN stakeholders with relevant, balanced and objective information to assist them in understanding news and developments that affects their work and/or their health. Local Geographic Level Engagement These engagements will improve our understanding of the needs and priorities of residents in each LHIN sub-region. This will drive our population health approach by allowing us to focus our efforts in the right places and on the right issues. This sub-regional approach to engagement will allow us to engage with health service providers where they provide services and connect residents with HSPs to co-design improvements. Population-based Targeted Engagements This approach to community engagement will ensure that we have the information we need at the sub-regional level to make good decisions about the kinds of health care services we and our partners plan and deliver. It requires an analysis of the groups most impacted by a particular project or decision, and involves finding the best way to provide a meaningful opportunity for these groups to participate in the decision making process. Citizen Advisor Program The Toronto Central LHIN will establish and maintain a list of individuals who have indicated their interest in sharing their experience and ideas for improving our health care system with us. These patients, caregivers and residents will have the opportunity to engage with us in the way that best suits their experience, skills and comfort level. These opportunities may include questionnaires and surveys, focus groups, LHIN-led committees and project level planning tables. Knowledge Exchange across Toronto Central LHIN This element is based on the recognition that many of the Health Service Providers in our LHIN are already working closely with patients,

	caregivers and residents to plan, implement and evaluate health care improvements. The Toronto Central LHIN will try to find ways to leverage this great work to help inform our own planning and that of HSPs who may not have the resources or capacity to carry out their own extensive engagements. We will work towards establishing channels of communication between the Toronto Central LHIN and our Health Service Providers at the sub-regional level to foster cross-learning and analysis of engagements that are taking place in each LHIN sub-region. In addition, the Toronto Central 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. • Developing new communications tools focused on the education of patients and caregivers on the options for accessing services and self-management. • Facilitating public and patient presentations at Toronto Central LHIN Board meetings and delegations to Board. • Including patient/client, family, caregiver representatives on advisory groups, project level committees and issue specific focus groups. • Facilitating staff and Board community tours. Capital Planning Process Community engagement requirements are included in all Toronto Central LHIN funded projects and integrations and changes requiring LHIN oversight including capital projects. The Toronto Central LHIN-HSP reference group of community engagement professionals collaborates to develop engagement tools and share strategies and best practices. Francophone Population Standing processes for including Francophone community voices in Toronto Central LHIN planning and decisions: • Partnering with the Toronto Central LHIN's French Language Services (FLS) Health Planning Entity, Reflet Salvéo to engage local community groups and Francophone agencies around the IHSP-4 (2017-2020). • Toronto Central 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.
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	• Cultural competency for better FLS delivery, moving towards bilingual organization and strengthening active offer training will continue to be offered to Toronto Central LHIN HSPs. The training will target both service providers and Francophone patients and families. • Francophone survey regarding barriers to accessing primary care services. Support Reflet Salvéo's attachment strategy to PHC. • Toronto Central LHIN will continue to focus on reaching the large and growing number of Francophone immigrants and refugees who face multiple equity issues by building relationships with community leaders and agencies serving this population. • A similar focus will be devoted to improving equitable access to French-language services for vulnerable groups such as people living with, affected by, and or at risk of being affected by HIV/AIDS. Toronto Central LHIN ensures that Francophone engagement is included in Toronto Central LHIN priority initiatives and uses translation and interpretation to support Francophone participation. • The LHIN will promote the use of the linguistic variable across current and oncoming initiatives. We will continue discussions to assess where in the referral process it is appropriate to identify Francophone patient language preference and apply required changes. • The LHIN will support ongoing discussion on Coordinated Access to Francophone Mental Health and Addiction services in GTA. The LHIN will continue the collaborative work started in 2014-2015 to optimize the existing centralized access systems tools and processes across the Toronto Central, Central, and Central-East LHINs: ACCESS Point, Streamline, and Single Access. • The LHIN will incorporate Francophone client engagement into its mental health and addictions capacity-building planning so as to create service models for complex and at-risk clients that are integrated within the care continuum at local (Health Links) and regional levels (GTA LHINs). • The LHIN will continue to support the work of the Coordinating Table of agencies serving Francophones living with HIV/AIDS. Indigenous Population There are a number of ongoing forums to engage Indigenous communities in Toronto Central LHIN: • The LHIN has partnered with Toronto Public Health to develop a road map for enhanced planning for Indigenous health services. The Toronto Indigenous Health Advisory Circle of Toronto will be a partner in the development of this plan.
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	• Participation along with Toronto Public Health in an Urban Aboriginal Roundtable for the City of Toronto with broad membership for Aboriginal agencies. Toronto Central LHIN is a member of the Provincial LHIN Aboriginal Network, which engages provincial Indigenous, First Nations and Metis stakeholders on provincial issues and strategies. Ongoing engagement processes include participation in Indigenous Forums and traditional events. Toronto Central LHIN partners with indigenous agencies to undertake Indigenous community-led engagement processes. For example Anishnawbe Health Toronto led engagement with Indigenous Youth experiencing mental illness and addictions to inform the design of new services for young Aboriginal people with mental health and addictions issues.
MPPs	Toronto Central LHIN engages MPPs and their staff regularly through direct contact and problem-solving for specific issues, regular targeted communiqués including briefing notes, fact sheets, key messages, and corporate communications vehicles – social media, news media and publications. Toronto Central LHIN has one-on-one meetings with MPPs and staff regarding specific local issues and initiatives. Toronto Central LHIN collaborates with MPPs' offices on local community engagement activities. Toronto Central LHIN holds annual or bi-annual meetings between all MPPs, the LHIN Board and CEO regarding key health system transformation initiatives. Toronto Central LHIN has an annual event with MPPs' and their constituency staff to inform staff about Toronto Central LHIN and key initiatives and impact on local health services and constituents.
City of Toronto	Toronto Central LHIN and GTA LHINs and City have established 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 includes five LHIN CEOs and executives representing key city departments impacting population and community health. The LHIN is also actively engaging with the City and Toronto Public Health to align our capacity planning with city's expansion plans. The LHIN engages with City Councillors on key issues that are of interest in their Wards or relevant to their committee roles.

	We also work with specific City Departments on relevant initiatives, particularly related to services for high-needs populations including: Toronto Public Health, Emergency Management System, City Planner; Long-Term Care Homes and Services; Shelter Support and Housing, Toronto Community Housing, TTC; City's Seniors Strategy Expert Panel.
eHealth Stakeholders	There are various tables and processes for engaging ehealth stakeholders to steer, guide and support implementation of Toronto Central 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
Other Partners	Toronto Central 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.

References:

- 1- Toronto Central LHIN Health Service Providers: Numbers of Providers and Services, March 2017. Based on Service Accountability Agreements (SAAs) and Self-Reported Initiative (SRI) ID.
- 2- 2015-16 estimates –Ministry of Finance budget estimates for Toronto Central LHIN. Ministry of Finance
- 3- Ranges of inflow to TC LHIN hospitals, 2013/14, IHSP Environmental Scan, MOHLTC Health Analytics Branch. June 2015
- 4- Census: Census Profile - Age, Sex, Marital Status, Families, Households, Dwellings and Language for Canada, Provinces, Territories, Census Divisions, Census Subdivisions and Dissemination Areas, 2011 Census. 2011 Census Statistics Canada 98-314-XCB2011007
- 5- Population counts by age group and neighborhood. Toronto/Ontario Community Health Profiles Partnership. Accessed 2016.
http://www.torontohealthprofiles.ca/a_dataTables.php?varTab=HPDtbl
- 6- NHS:2011 NHS Dissemination Areas , National Household Survey, 2011. 2011 National Household Survey - Statistics Canada
- 7- Urban Heart, 2014 [2006 Census, Ontario Marginalization Index].
<http://www.torontohealthprofiles.ca/urbanheartattoronto.php>
- 8- Hospital births for women 15-49, 2012/13 to 2014/15. Ontario Community Health Profiles Partnership.
<http://www.torontohealthprofiles.ca/ont/dataTablesON.php?varTab=HPDtbl&select1=7>
- 9- Number and rate of deaths for total population. Death Tables, Vital Statistics, FY2011, Ministry of Health and Long-Term Care, IntelliHealth ONTARIO, extracted January 2017, MOHLTC , IntelliHealth.
- 10- Chronic diseases in TC LHIN. 2014/15. Toronto Community Health Profiles Partnership.
<http://www.torontohealthprofiles.ca/ont/dataTablesON.php?varTab=HPDtbl&select1=7>
- 11- Toronto Central LHIN Primary Care Census Database. Number of primary care physicians in TC LHIN, 2017.
- 12- Toronto Central LHIN. Interdisciplinary Healthcare Providers in Toronto Central LHIN Primary Care Setting Survey Results. February 2017.
- 13- Primary Care: Enrollment and Continuity of Care, 2011-2013. Ontario Community Health Profiles Partnership.
<http://www.torontohealthprofiles.ca/ont/dataTablesON.php?varTab=HPDtbl&select1=7>
- 14- Emergency Department Visits . 2015/16. National Ambulatory Care Reporting System (NACRS), MoHLTC, IntelliHealth
- 15- Hospital separations and percentage of ALC days . 2015/16. Discharge Abstract Database, MOHLTC , IntelliHealth. http://www.torontohealthprofiles.ca/a_dataTables.php?varTab=HPDtbl
- 16- Hospitalizations for Prenatal Conditions, Women, Ages 15-49 (2011-2012). Toronto Community Health Profiles Partnership, Extracted: 2016.
- 17- Shelters for Homeless population and units, 2016. City of Toronto
- 18- TC LHIN financial statements FY15-16. Based on 15-16 actual – audited statement.
- 19- Population Estimates: 2015 LHIN sub-region population estimates. Health Analytics Branch, MOHLTC, 2017
- 20- Globe and Mail. Toronto now the fourth-largest city in North America,
<http://www.theglobeandmail.com/news/toronto/toronto-now-the-fourth-largest-city-in-north-america/article9317612/>
- 21- Comprehensive to the Core: Planning Toronto's Downtown. 2014. City of Toronto. Extracted, 2017. <http://www.toronto.ca/legdocs/mmis/2014/te/bgrd/backgroundfile-69191.pdf>
- 22- The Toronto Seniors Strategy The Toronto Seniors Strategy Towards an Age-Friendly City by the City of Toronto (based on Census 2011)
<https://www1.toronto.ca/City%20Of%20Toronto/Social%20Development,%20Finance%20&%20Administration/Shared%20Content/Seniors/PDFs/seniors-strategy-fullreport.pdf>

- 23- Immigration and Ethnocultural Diversity in Canada, Statistics Canada (based on 2011 Census) .
<https://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.cfm>
- 24- City of Toronto - Toronto Facts
<http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=dbe867b42d853410VgnVCM10000071d60f89RCRD>
- 25- Statistics Canada, 2014. Table F-17 Family data - Low income (based on before-tax low income measures, LIMs), 2012. Available from The Community Data Program. Statistics Canada. 2012. Toronto, Ontario (Code 3520005) and Ontario (Code 35) (table). Census Profile. 2011 Census. Statistics Canada Catalogue no. 98-316-XWE. Ottawa. Released October 24, 2012.
<http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E>
- 26- Francophones in Ontario. http://csfontario.ca/wp-content/uploads/2014/10/2014.09.18-Francophones-in-Ontario_infographic_J.pdf
- 27- 2013 Street Needs Assessment Results.
<http://www.toronto.ca/legdocs/mmis/2013/cd/bgrd/backgroundfile-61365.pdf>
- 28- Dwelling units completed in Toronto, City of Toronto
- 29- Long Term Care Capacity Report, Ministry of Health and Long Term Care
- 30- Access to Care, 2016-- Cancer Care Ontario
- 31- A Reclamation of Well Being: Visioning a Thriving and Healthy Urban Indigenous Community. Toronto's First Indigenous Health Strategy 2016-2021. 2016.
<http://www.toronto.ca/legdocs/mmis/2016/hl/bgrd/backgroundfile-93077.pdf>