Toronto Central **LHIN**

Report to the Community
2011/12

Partners in Action

Delivering Excellent Care for All

Transforming the system for your health.

Ontario
Local Health Integration Network

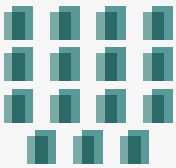
At-a-Glance:

Healthcare Improvements in Toronto Central LHIN in 2011/12 and what they mean for local residents

A large majority of people in the Toronto Central LHIN who visited the ER last year were treated, sent home or admitted to hospital within the **target wait time.**

Fewer people spent long periods in local hospitals waiting to be transferred back home, to long-term care or another setting – a situation called Alternate Level of Care (ALC).

Toronto Central LHIN's ALC rates reached the **lowest level ever** last year.



Access1

15 Toronto Central LHIN agencies joined forces to offer one service – Access 1 – enabling people in need of mental health services to make one phone call to access immediate support services and programs including supportive housing and case management.

Three Toronto family physicians joined the Toronto Central LHIN to support a strategy to connect people to primary care in the city.

Language Services Toronto provides real-time phone interpretation 24/7 in 170 languages to newcomers and others with limited knowledge of English.

Bulk-purchasing cuts some hospitals' phone interpretation rates by up to **80%**. Savings are reinvested in patient care.

Health care organizations are working together to get stroke and hip and knee surgery patients into rehabilitation and recovery sooner, improving their health and experience.

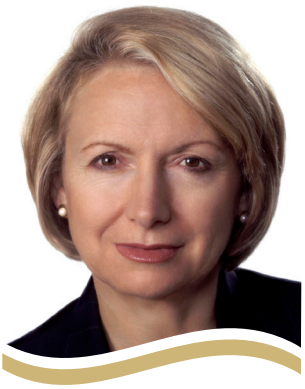
Last year:

Hospitals, community agencies and primary care coordinated their services more for patients.

We began to expand outpatient stroke clinics and rehab services for hip and knee patients including new ambulatory clinics at Bridgepoint and West Park.

Message to the Community

It is our privilege to present you with the Toronto Central (TC) LHIN's Report to the Community for 2011/12 – *Partners in Action: Delivering Excellent Care for All.*



Angela Ferrante
Board Chair

Camille Orridge
CEO

The TC LHIN plays a unique role in health care. We look both at the needs of all people who receive care in our LHIN and at all of the services and then work to create an integrated, high quality system for everyone.

As we reflect on the past year, our outlook is optimistic. The 2011/12 year saw the release of the Commission on the Reform of Ontario's Public Services and Ontario's Action Plan for Health Care. Both of these documents set out in plain and clear terms the need to make bold changes to the health system to improve quality, the value of our investment in health care and the sustainability of our publicly funded health care system.

The TC LHIN fully subscribes to this call for change. We know that there are formidable challenges. However, we also view this as a rare moment to make fundamental changes for the good of all citizens and the health system upon which they depend.

The first challenge is that we have a fragmented health system. The patient experience is the barometer of the quality of care. Patients are telling us that they have good experiences with individual services and value the care that they receive. Yet, despite the abundance of services and agencies in the city, patients find it difficult to know where to turn for help. It is a challenge to move between services, including from hospital back home, or between their family physician and specialists. The fact that many agencies and clinics are not open on weekends is a real problem for those who can't wait for care. Some say they don't get good information about their health care and feel excluded from decisions affecting their lives.

Health inequity is another significant issue. Torontonians receive different standards of care depending on where they live, who they are and the language they speak. Low income earners have higher rates of mental illness and addictions and diabetes, are less likely to receive primary care and are more likely to be hospitalized as a consequence of these and other factors. Many Aboriginal people do not receive services that embrace their culture, contributing to distrust in mainstream health care.

The third big challenge is the cost and efficiency of health care. Given the aging and growing

population, the health system will continue to grow. However, as Ontario tackles its historic deficit and debt, it's clear we must bring down spending to an affordable level. We believe the key to curbing the overall cost of health care is improving quality. Quite simply, high quality, safe care ultimately costs less.

As you review this Report to the Community, you will get an overview of some of the programs and services across the city that address these issues. Our main goal is to put people first and make real, measurable progress toward excellent care for all.

We are pleased to confirm that over the past year patients benefitted from improved access to important services. They waited less time for treatment in local Emergency Rooms and, having received that care, they spent less time in hospitals waiting to be transferred to rehabilitation, long-term care or home with the necessary supports. We measure the wait time spent inappropriately in hospital (we call it the Alternate Level of Care or ALC rate) and we track it carefully so that we can lower it – saving money for the health care system and giving patients more appropriate care for their needs.

Last year we also made important progress in addressing health inequities. Of particular note, the LHIN spearheaded the creation of one phone interpretation service for newcomers and others facing language barriers. Because of that work, hospitals, community agencies and clinics across Toronto and the GTA are now able to connect patients to live interpreters by phone to help them to communicate with their doctors and nurses. And because services are amalgamated into a single provider, future costs for this service will come down significantly.

As we go forward, health service organizations must continue to work together in new ways for patients. Many of our problems today have been with us for some time. And some changes will take time before they are seen and felt by patients. The answers do not lie within single organizations. They are found in collective efforts. Recent achievements prove this.

In June 2012, the TC LHIN released a new Strategic Plan, a course of action to improve local health care over the next few years. This Plan reflects the input of patients, residents, and players across health care through consultations held last spring and summer. This Plan steps up local actions to enhance quality, reduce inequities, and make health care sustainable.

Finally, because we believe that we can learn the most by listening to the patient, the LHIN has committed to measuring and reporting on how patients experience the health system and to hearing directly from people about what is important to them. As part of this initiative, we will make certain that we capture the voice of those in our community with the greatest needs who, all too often, are not well served or heard in the health system.

The Board of Directors and the staff of the TC LHIN look forward with excitement and determination to continuing to build a great local health system for everyone.

Angela Ferrante
Board Chair

Camille Orridge
CEO

Voices of the Community

Meeting with Patients

Listening to the people who use local health services is the only way to ensure that decisions take their experiences and perspectives into account.

Last year, the Toronto Central (TC) LHIN worked with Patient Destiny, a patient advocacy group, to bring together a diverse group of patients, clients and caregivers. The group included people of different ages, health issues and experiences. They shared their personal experiences – good and bad – and offered ideas for how to improve the local health care system.

The report "Meeting with Patients: Their Experiences and Perspectives" is being used for local health care planning. Here are some of the patients' stories.

"The (health care) system is not designed to encourage patients as partners."

Participant, "Meeting with Patients: Their Experiences and Perspectives"

Judy's Story

"My first bout with cancer was three years ago and the treatment that followed was a series of mistakes and mishaps from start to finish. Thyroid surgery did not go well and I spent a month in the hospital - two weeks in ICU. On being discharged, I was given the wrong medications."

Judy is a retired single senior who lives alone. Little wonder that she approached treatment after her second cancer diagnosis with some trepidation.

"About 18 months later I was diagnosed with breast cancer. Following my first mammogram in years I got a call from Princess Margaret telling me to come in, that an appointment had been made for me. I knew this had to be bad news and I was right: I had breast cancer.

"But my experience this time around was like night and day compared to what I'd gone through before. I was connected with a new endocrinologist and received great support at all levels."

"Patients need to have access to their personal health information so they can play a more active role in their own care."

– Judy, participant

Judy's Story

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Judy credits the discussion sessions, started by the late oncologist Dr. Robert Buckman, for allowing patients to be themselves and for restoring their humanity.

"Through these sessions, facilitated by a social worker and a nurse, I connected with community-based support groups such as Gilda's Club and Wellspring where patients share experiences and listen to others in a group therapy setting. And we are able to find strength in sharing and comparing notes. It helps me to reach out to others and share what I've learned and listen to their particular experiences. We're all travelling along the same road."

Improving Aboriginal Health and Healing

Toronto's Aboriginal community is one of the most vulnerable and hidden populations in the country. A number of initiatives in TC LHIN are shining a light on Aboriginal health in the city.

In order to address the social determinants of health including poverty, intergenerational trauma and social isolation in the Aboriginal community, wholistic care models which address health, mental and spiritual needs are required.

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

Val's Story: In Her Own Words

"I have coped with being diabetic by embracing my culture. I never knew my culture before. One day I went to an Anishnawbe Health Clinic and met a counselor that changed my life. She encouraged me in every way so that my self-esteem could grow and I could feel better about myself. Seeing Healers, participating in ceremonies, going to teachings and living the Traditional way of life has helped me immensely."

"I've been a diabetic (type 1) since 1987. I participated in a diabetic survey and one of the things they asked us to do was a project that told our story on how we cope with the disease. I knew what I wanted to do from the start, a quilt. Since I like crafts, it was an easy decision. First I drew an outline on paper which included the symbols that represent the stages of my disease. I started with a tree as the focal point. Trees to me mean strength and resilience. I divided the tree in half. The left side is the negative, dark side of the disease. It's the side that held me down for many, many years. I was very depressed and a short time after I found out I was diabetic, I tried to commit suicide. Giving myself insulin shots daily and being told that I had to do this for the rest of my life was something that was extremely hard to accept.

The positive side of the quilt was much easier to do. Anishnawbe Health was a major factor in my learning to cope with diabetes. Learning my culture

Francophone Community

Geography is a barrier to care for some Francophones in the city. Members of the community have voiced concerns that there are not enough services, particularly for newcomers and immigrants. They have also pointed out that services are fragmented.

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

Reflet Salvéo and the three LHINs are creating a map of health care services, needs and gaps to be completed in 2012. This map will paint a clearer picture about where members of the Francophone community live and how far they have to travel for health services. It will also provide insight into the mix of services available for this unique community.

Reflet Salvéo's first annual Advisory Report to the LHINs on the needs and priorities for FLS health services identified additional gaps including mental health and addictions services, particularly for youth who are moving into adulthood, and the need for community-based services such as adult day programs and home supports for aging Francophones. The report advises that the overall goal is to create a continuum of French Language Health Services covering the entire life cycle. This Report also underscores the important influence that cultural identity has on the health and wellbeing of Francophones and the need for "Active Offer" – which requires providers to proactively offer services in French rather than patients having to request services in their first language.

has made me more aware of how important our lives are. Participating in the ceremonies, praying, going to teachings, seeing healers and counselors has been instrumental in a healthier attitude towards the disease. While I was making each symbol I realized how this disease has taken control of every aspect of my life. Since I have never fully accepted being diabetic this project turned out to be very therapeutic.

I'm still waiting for a cure!"

* Taken from Lavellée, L.F. & Howard, H.A. (2011). *Urban Aboriginal Diabetes Research Project Report.* Anishnawbe Health Toronto. Toronto, ON.

"Seeing Healers, participating in ceremonies, going to teachings and living the Traditional way of life helped me immensely."

– Val, participant

Improving Quality of Care

Toronto Central LHIN's top priority is improving the quality of care that patients receive. High quality care is safe and equitable. It also means that patients have a positive experience because they are informed, supported and respected.

This past year, the TC LHIN led and funded different programs and services to enhance the quality of health care in central Toronto. These efforts were designed to benefit people with the greatest needs who depend on the health care system the most, including frail seniors and people with mental illness and addictions. The following spotlights some of these programs and services.

Top Three Ways Caregivers Used their Funds:

1. Pay for more informal care – through a relative, friend, neighbour etc.;
2. Pay for more hours from a personal support worker;
3. To purchase extra health care supplies.

Supporting Caregivers

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

A similar pilot is underway through the Hospital for Sick Children for caregivers of medically complex children.

Petroula's Story

"My mother means everything to me," said Petroula. "She was a good mother. She did everything for me. And now I want to give her what she needs."

Petroula, 69-years old, lives with her mother, 94-year old Eleni. Her mother's mind is still sharp and her wit is still intact but she lives with chronic health conditions including congestive heart failure, diabetes and hypertension.

Everyday, Petroula helps her mother with everything from bathing to walking down the hall. And though she's devoted, caring for her mom 24/7 has started to affect her own health and wellness.

Through the TC LHIN Caregiver Framework for Seniors pilot project, Petroula was able to use additional funds to receive respite care. For her these extra dollars for respite care allowed her to have a couple of spare hours a week and finally gave her time to enjoy a regular coffee break with her husband, Frank – something she rarely does.

"I would rate it a 10/10 that's for sure," said Petroula. "How can I not - especially if that time gives me more freedom and peace of mind."

She says the Caregiver project has improved her quality of life and gave her peace of mind knowing that her mother is living where she wants to be, in the comfort of her home.

Caregiver Framework for Seniors Project by the Numbers*:

- On average, informal caregivers provide about 50 hours of care per week to a loved one;
- 84.3% of caregivers live with their loved one they are caring for;
- All caregivers in the program had experienced high level of stress related to their role.

** Alzheimer Society of Toronto.*

Supporting Those with Behavioural Issues

Today in Toronto, an estimated 39,244 people live with dementia. And with the aging population, the Alzheimer Society of Toronto predicts this number will almost double by 2031.

In a recent report, Gail Donner, Chair of the Long-Term Care Task Force on Resident Care and Safety concludes that long-term care homes are caring for more elderly residents living with dementia and other behavioural problems. She recommends that sufficient supports from specially-trained staff and specialized units are required to appropriately and safely care for these seniors.

The TC LHIN's Behavioural Supports for Seniors Program will help patients and their families affected by dementia and neurological conditions navigate and access services that meet their individual needs.

Led by Baycrest, the program brings together community care agencies, hospitals and long-term care homes. When fully launched in 2012, the program will provide a range of services tailored to different seniors' needs including:

- **A new transitional Behavioural Support Unit** in Baycrest's Apotex long-term care home designed to support seniors with highly complex and difficult behavioural challenges who require specialized care because their behaviours pose a threat to themselves or others.
- **Outreach and crisis teams** – Specially-trained teams will go into long-term care homes and other places where seniors live. Crisis teams at Woodgreen Community Services offer telephone and and in-person counselling and support to seniors and families in crisis.
- **Education** – Organizations will launch a new program to educate personal support workers and other health professionals in how to care for people with complex and difficult behaviors. Mount Sinai Hospital is also developing a skills-building program for family caregivers.

Frank and Harriet's Story

Frank and Harriet were college sweethearts when they married 50 years ago. He was a teacher and businessman; she – an artist and writer. Together they raised a family.

Today 77-year old Frank lives at Baycrest's Apotex Centre. He was diagnosed with Frontal Temporal Dementia, a condition that left him with uncharacteristic behaviour, affected his ability to speak and caused severe memory loss.

Baycrest was the right fit for Frank.

The communication between doctors and caregivers was key. And it is this type of communication and access to a continuum of connected services and supports that is at the core of the TC LHIN Behavioural Supports Strategy.

"It became like a broken telephone, I had to interpret Frank's condition for different professionals. Coming to Baycrest has changed my life, everybody just talks to each other and communicates."

– Harriet, Frank's wife

All Hands on Deck: Measuring Health Quality

In the past, each organization and sector worked in silos to measure and improve quality of care within their own walls. While these efforts were crucial, what was missing was collaboration to improve patient care.

Most problems occur during transitions – when patients move from one service to another. Yet there has been little information about the patient's experience across their care journey.

Last year the LHIN launched a different approach to measuring and addressing health quality.

TC LHIN brought all parts of the health system to the table from hospitals to community health centres to primary care to public health. Patients and caregivers provided feedback throughout the process.

All sectors agreed to measure and work on the same quality improvements for patients. Each health service provider committed to be accountable for tackling their part of problems including avoidable ER visits, hospital readmissions and improving the patient experience. By having hospitals, community agencies, long-term care homes and others all working together we will be much more likely to fix these problems for patients.

Integrated Care Helping Most Complex Patients

As they age, people want to be able to maintain healthy independent lives in their own homes and communities. But all too often, seniors with complex care needs end up in the ER or hospital because they do not have the supports they need at home or in their community. Once hospitalized, many seniors decline quickly and are unable to regain their independence.

To provide better health outcomes and an improved quality of life for seniors, TC LHIN supported the Toronto Central Community Care Access Centre in their work to develop the Integrated Client Care Project. This program has all health sectors working together to support older people to maintain their health and independence, where they live. Designed for seniors with at least two conditions such as congestive heart failure and chronic obstructive

pulmonary disease, and who are at risk and homebound, the program has primary care, community care and hospitals working hand-in-hand with the patient and family.

Trevor's Story

Aging brought a host of serious health problems, for 89-year old Trevor* who had lived a full life as an academic, artist and traveller. In his later years Trevor lived with severe osteoarthritis and Parkinson's disease. He had limited mobility and had trouble communicating. He often went to hospital when health issues arose because he found it challenging to visit his family doctor.

With the help of a Care Coordinator at the Toronto Central Community Care Access Centre (CCAC), Trevor became part of an Integrated Care Team that made house calls. His team included his family doctor, a nurse practitioner, a physiotherapist, occupational therapist, speech language pathologist, registered nurse and a personal support worker.

The Care Coordinator ensured that all team members worked together providing appropriate care and support. She even arranged for Trevor to attend specialist appointments. When his doctor was unable to make a house call, she organized teleconferences from Trevor's bedside to ensure he was able to communicate live with his doctor.

As a result of this integrated approach to his care and support, Trevor was able to live in the comfort of his home for as long as possible.

As a result of this integrated approach to his care and support, Trevor was able to live in the comfort of his home for as long as possible. He no longer relied on the ER since his Integrated Care Team could better manage his situation and respond quickly to any changes in his condition.

After many months, Trevor was admitted to hospital where he later passed away. During his entire ordeal, he was supported at every step with an Integrated Care Team that put Trevor at the centre of his own care.

**Name has been changed.*

Alternate Level of Care – Getting Patients the Right Care in the Right Place

Too many patients are still in limbo waiting in hospitals to be transferred to rehabilitation, home or to long-term care– a situation called Alternate Level of Care (ALC). Long hospital stays can be harmful to their health and their quality of life.

When the TC LHIN took on the Alternate Level of Care issue, we were not meeting our performance target. The TC LHIN organized providers to mount a concerted campaign to reduce ALC by supporting patients – particularly seniors and others with high needs – to get care in the right setting and receive more home and community care.

In 2012, the TC LHIN achieved its ALC target. Overall, the number of people waiting in TC LHIN hospitals for long-term care has gone down by 43 per cent since Fall 2009. Supporting seniors in

their community and at home has resulted in a 56 per cent reduction in the number of people who were ALC in acute care hospitals and waiting for long-term care. There has been a 33 per cent reduction in the number of people who were ALC in rehabilitation and complex continuing care hospitals waiting for long-term care.

Improving Equitable Access to Care with the Help of Technology

Doris's Story

Ever so slowly, Doris and her brother, John, push their 95-year mother, Sylvia, through the garden terrace at a west-end Leisureworld long-term care home.

"My mother means everything to me… she's like the pillar holding our family together," said Doris.

But the strength of the pillar was recently tested when Doris's three other siblings decided to move their ailing mother, Sylvia, from her home into long-term care.

"The process was challenging because we had to deal with the reality that her living in her own home was no longer viable."

Meet Enza L'Aurora, a Care Coordinator at Toronto CCAC.

"We were in crisis and Enza recognized that," said Doris. "The process for us was very quick and within a week we heard from the first available home. This was all done so quickly and it was done professionally, with Enza giving it the human touch. The technology allowed for it to be done quickly."

And that technology is known as Resource Matching and Referral (RM&R). RM&R is an electronic information referral system that enables patients and clients to be matched to the most appropriate service or program based on the clinician's assessment and patient needs.

With RM&R, health professionals are equipped a database of the full range of available programs and services, taking the guess work out of matching up a patient to the available services.

Toronto Central LHIN Continues to Reduce Long-Stay ALC

In 2010/11, TC LHIN initiated a series of supports to help long-stay ALC patients waiting in hospital more than 40 days.

Last year, 134 long-stay ALC patients were transitioned to the right place of care.

While this may seem small, the impact is enormous: Transferring one ALC patient who has been in hospital for one year makes a bed available for 10–40 other people over the year.

Doris's Story

...Continued from previous page

For patients this means fewer delays and quicker referrals to the services they need. Families have less paperwork to worry about and can focus on the well-being of their loved ones.

"It's tighter, neater and available to a lot of people," said Sandy McCamus, Resource Care Coordinator Toronto, CCAC. "And it's easier to share the information in the referral application with a client if they want to see what I'm entering."

Faxed patient applications, paper charts and referral applications with varying information from agency to agency, are now a thing of the past. The technology guides health professionals, keeping them on track with prompts and alerts if they miss a step or miss filling out crucial pieces of the client's information, like weight and height.

Doris says the process from start to finish was smooth and that she was kept in the communication loop the entire time.

Resource Matching and Referral in the Toronto Central LHIN

One of the fastest growing regional eletronic referral systems in Ontario.

Who uses RM&R?

84
health service providers

24,000
health professionals

75,000
patients and counting

(2008-2012)

Increasing Access through Strengthened Primary Care

Primary care is often the patients gateway and most constant link to the health care system.

In Toronto we have some unique challenges with primary care. And while there is a relatively high number of family doctors (1,820) and a variety of practices and clinics in the city, we also have the highest number of adults without primary care in Ontario. Many people who are sick and at risk are going without regular contact with a family physician or primary care team.

TC LHIN has the lowest rate of patients who were referred to a family physician using Ontario's Health Care Connect Program.

The TC LHIN initiated a local primary care strategy last year to increase people's access to primary care services in the city. Our first priority is to ensure every resident of the LHIN has a primary care physician. Our long-range

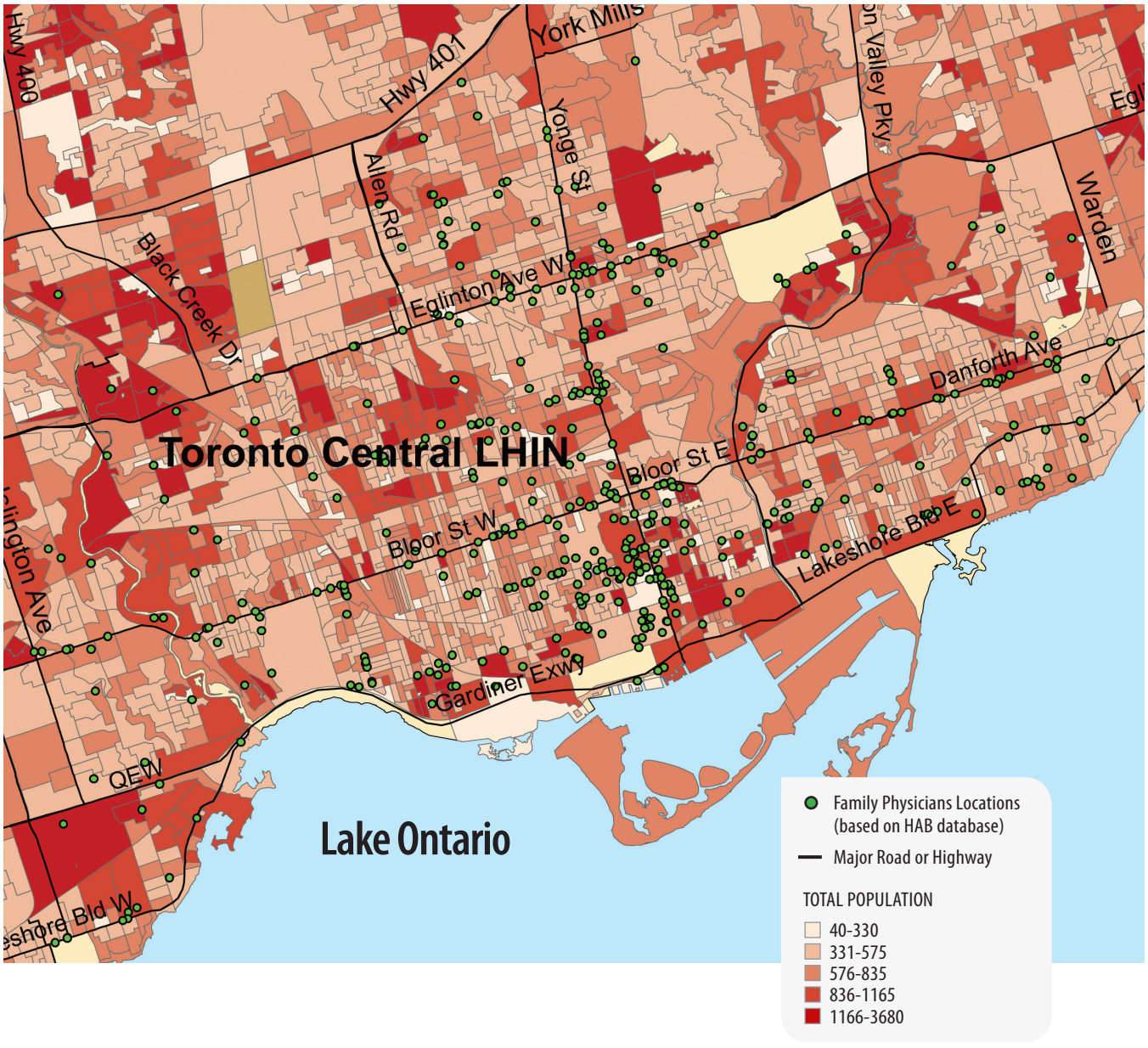
goal is to ensure the right resources are in place, integrated and coordinated for patients.

Our initial efforts will focus on improving access to family physicians because this is where we have the most obvious gaps and the greatest fragmentation. Ultimately, we are striving for more comprehensive primary care teams made up of physicians, nurses and nurse practitioners, pharmacists and other professionals.

In 2011/12, three Toronto family physicians joined the TC LHIN as primary care advisors. They provide expert advice to the LHIN about primary care. They lead the engagement of primary care providers, so that they are involved at every step.

The map below shows that some of the city's high density (and high needs) neighbourhoods have fewer family physicians close by.

Population by CT (2006 Census) and Family Physician Location (based on HAB database) – 2012



Providing Excellent Health Care for *All*

For the Toronto Central LHIN, equitable health care means everyone has access to the same high standard of care no matter who they are, what language they speak and where they live.

Last year various projects in the LHIN began to remove some of the barriers encountered when people seek health care.

Improving Health Access in St. James Town

St. James Town sits in the heart of downtown Toronto. Its pulse is measured by the incredible diversity and strong social and cultural networks of the 16,000 plus residents who call one of the 18 high-rises in North St. James Town home.

And when fire broke out at 200 Wellesley St. East in September 2010, the community came together to help roughly 1,200 people who were displaced.

Yet while the blaze brought people together, it also exposed how many people in the neighbourhood were facing health challenges. There are a vast array of important services in the community, but they have not been well coordinated or readily available to St. James Town residents.

Our partners including the United Way, Toronto Community Housing and St. Michael's are all working toward a common plan to improve health access in this community. A series of community meetings in multiple languages will be undertaken starting in Fall 2012 so that we can hear from residents about what they think needs to be done.

For St. James Town, the future of health care could mean bringing more services into people's homes, buildings, schools, libraries and community centres.

Supporting People Living with Mental Health Illness and Addictions

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

Clients who are poorly served or not connected to service can end up being high users of the emergency department, hospital beds and other specialized resources, costing the system a great deal of money and often resulting in poor health outcomes.

Within the TC LHIN there are 69 community-based organizations funded to provide mental health and addictions services, along with nine hospitals, 17 Community Health Centres and hundreds of other primary care and social service agencies that provide care and resources for individuals with mental health and addictions issues.

Through consultations over the past several years, health care providers and consumers have highlighted a number of local challenges:

- Multiple, uncoordinated and inconsistent access points and sources of information;
- Insufficient capacity in local agencies to meet need;
- Fragmented services and lack of integration resulting in poor transitions between services;
- Poor quality data to enable proactive planning for mental health and addictions services; and
- Inconsistent focus on the needs of consumers and families.

The TC LHIN brought agencies together to tackle some of these challenges. We have made gains. But this is a starting point. The demand for mental health and addictions services is on the rise.

Providing the Right Supports Helps People Thrive

The Centre for Addiction and Mental Health (CAMH) continues to pioneer new ways of caring for people with mental health illness and addictions while changing attitudes about mental health. In June 2012, CAMH officially opened its new downtown campus that provides treatment in a community setting. The three new CAMH buildings sit within the bustling Queen Street West neighbourhood- literally removing the "walls" between people living with mental health illness and their communities.

One example of this modern approach to mental health care is a 40-unit apartment complex with around-the-clock health care support for people living with schizophrenia. More than 100 people who were previously institutionalized are now living with greater independence as part of a community as a result of this partnership between CAMH, the TC LHIN and community agencies, such as Regeneration House.

New and Expanded Services to Close Gaps

TC LHIN invested in the city's first supportive housing units geared toward people struggling to overcome addictions. As of March 2012, 93 per cent of the units were secured by those in need and early findings indicate that, on average, clients in this new housing are using the ER 68 per cent less than they were before.

Access 1 – Connecting Clients to Care

Over 2011/12, the TC LHIN joined forces with agencies to expand a program called Access 1. This program allows clients with mental health illness and addictions and their families to

easily access case management services and specialized Assertive Community Treatment Teams (ACTT) through one telephone number. By January 2013, 15 health providers will be on board.

Once clients place a call to Access 1, a specially-trained person is waiting on the other end ready to help the client navigate the mental health system and provide short-term support.

Prior to 2009, if a person in TC LHIN needed case management services, they would need to fill out multiple applications, meet different sets of eligibility criteria and fulfill specific processes.

Allison Hunt, director of the Mental Health Access Network says one of the biggest challenges for clients and families in need of mental health services is knowing where to turn to for help.

Access 1 is another program built on the successful coordinated access model for health in TC LHIN. The Coordinated Access to Care for the Homeless Program (CATCH) has connected 304 clients to primary care who otherwise would have had limited access.

In Central LHIN, the coordinated access model for mental health has been in place for four years. A survey indicates that almost 74 per cent of clients were "very satisfied with their overall experience" and 90 per cent would recommend the service to family or friends. Now TC LHIN and Central LHIN have partnered to develop a coordinated access model to help clients move seamlessly across the two LHINs.

The TC LHIN will continue with these efforts and we will work on strengthening the connection between mental health and other services including primary care, children and youth services and Aboriginal agencies.

John's Story

Last fall, John* found himself living at the Maxwell Meighen Centre on Sherbourne Street. He had no money; no job and no future. He said he had nothing to look forward to.

Then he met Charlene Crews, a senior case manage with Toronto Central LHIN's Co-ordinated Access to Care for the Homeless program (CATCH). The program connected John to a doctor – the first time in four years.

John, a borderline diabetic, also received guidance on how to manage his illness as well as treat his depression. He was astounded at the care he received and said that it was "an extremely positive thing to speak to people who really do care about what happens to you."

Now he envisioned a future for himself. CATCH provided him with a renewed hope and a positivity that he had not experienced in years.

**Name has been changed.*

Helping those Facing Language Barriers

Studies indicate that immigrants and others who do not speak English have better health outcomes and fewer health problems when they receive communications in their first language.

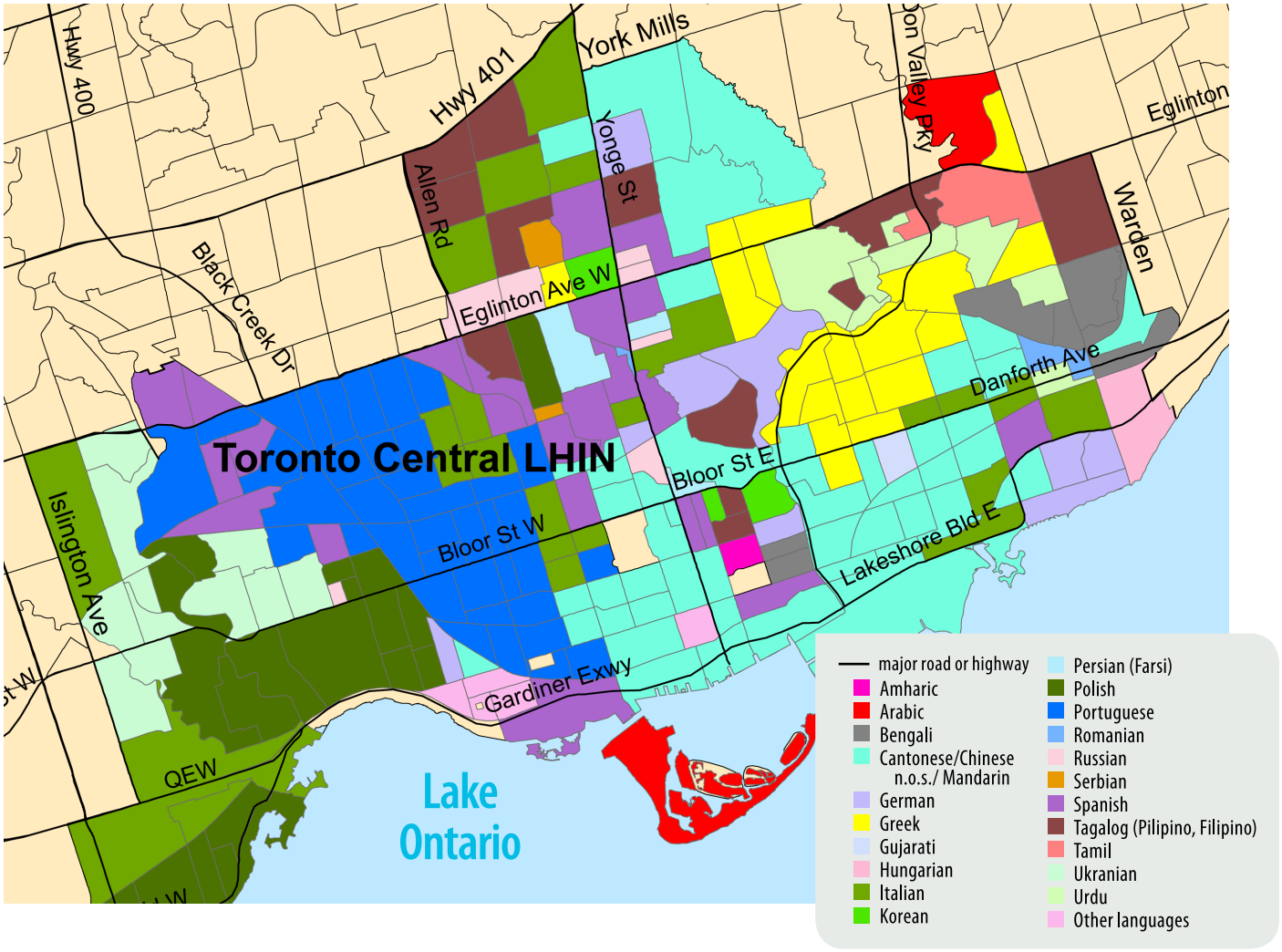
The TC LHIN saw that different hospitals were purchasing their own telephone interpretation services. Hospitals were all paying vastly

different rates on their own ranging from $1.71/minute to $8/minute.

Last year the TC LHIN called on the hospitals to bulk purchase telephone interpretation services in order to increase access to the service while reducing the cost to hospital and community agencies. With lower rates, the TC LHIN is funding local community agencies to join in 2012 in a new program called Language Services Toronto.

- Starting October 2012, hospitals and community agencies across Toronto and the GTA will offer phone interpretation to their patients.
- 170 languages will be offered through the new **Languages Services Toronto** Program.
- Hospitals will see their phone interpretation rates decrease by 80%, which will free up funds to reinvest in more language and other services for patients.

Top Languages based on Mother Tongue Excluding English and French by Census Tract, Based on 2006 Census



Snapshot of the Toronto Central LHIN Community

Uniquely Urban

Toronto Central LHIN is the only LHIN in Ontario's 14 that is completely urban. Home to 1.15 million people, Toronto Central LHIN is an extremely diverse area in terms of the population who lives here and the hundreds of thousands who come to the city for health care.

It is estimated that 32 per cent of the population aged 22 to 44 years old and 14 per cent of the population aged 65 years and older. By 2016, seniors will account for 14.8 per cent of the LHIN's population. Seniors aged 75 to 84 years old are growing faster than any other group; many are becoming increasingly frail as they get older.

The baby boomers are reaching an age where they will need more health care. There will be double the number of seniors living in Ontario over the next 20 years. While the importance of aging as a cost driver is often overblown and seniors are living longer and healthier, the fact remains that health care use and costs rise as people age.

Aboriginal Peoples

According to the 2006 Census, the city is also home to 16,200 Aboriginal people, one of the largest Aboriginal populations in Canada.

Toronto's highly diverse Aboriginal community is made up of many different First Nations communities from across the country Aboriginal peoples access a variety Aboriginal and non-Aboriginal services. Non-Aboriginal Health Service Providers (HSPs) often require adapted services to meet the unique needs of Aboriginal communities.

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

There is limited reliable information about the health status and health care use of Aboriginal peoples due to the fact that Aboriginal ethnicity is not flagged in health administrative datasets such as Institute for Clinical and Evaluative Services (ICES). For example, there is no available data regarding Aboriginal-specific fertility rates, maternity experiences, or birth outcomes in the GTA.

Francophones

Toronto has a substantial Francophone population of 53,000 (9.2 per cent of Ontario's Francophone population) many of whom are recent immigrants and/or visible minorities. Francophones are increasingly diverse with

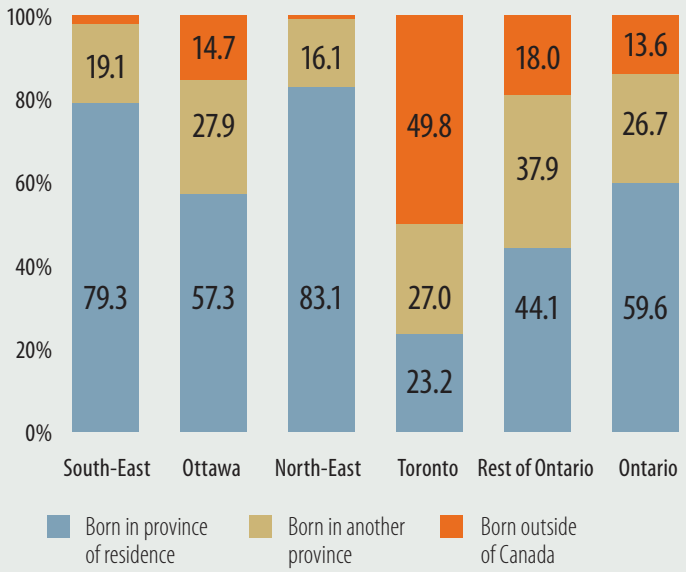
49.8 per cent born outside of Canada and a high proportion of recent immigrants, largely from African countries. Francophones are dispersed across the city and do not tend to live in any particular neighbourhoods. Likewise, French language health services are scattered across the TC LHIN which contributes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

Serving an Immigrant Population

In TC LHIN 41 per cent of residents are immigrants, 8.3 per cent of whom arrived in Canada between 2001 and 2006.

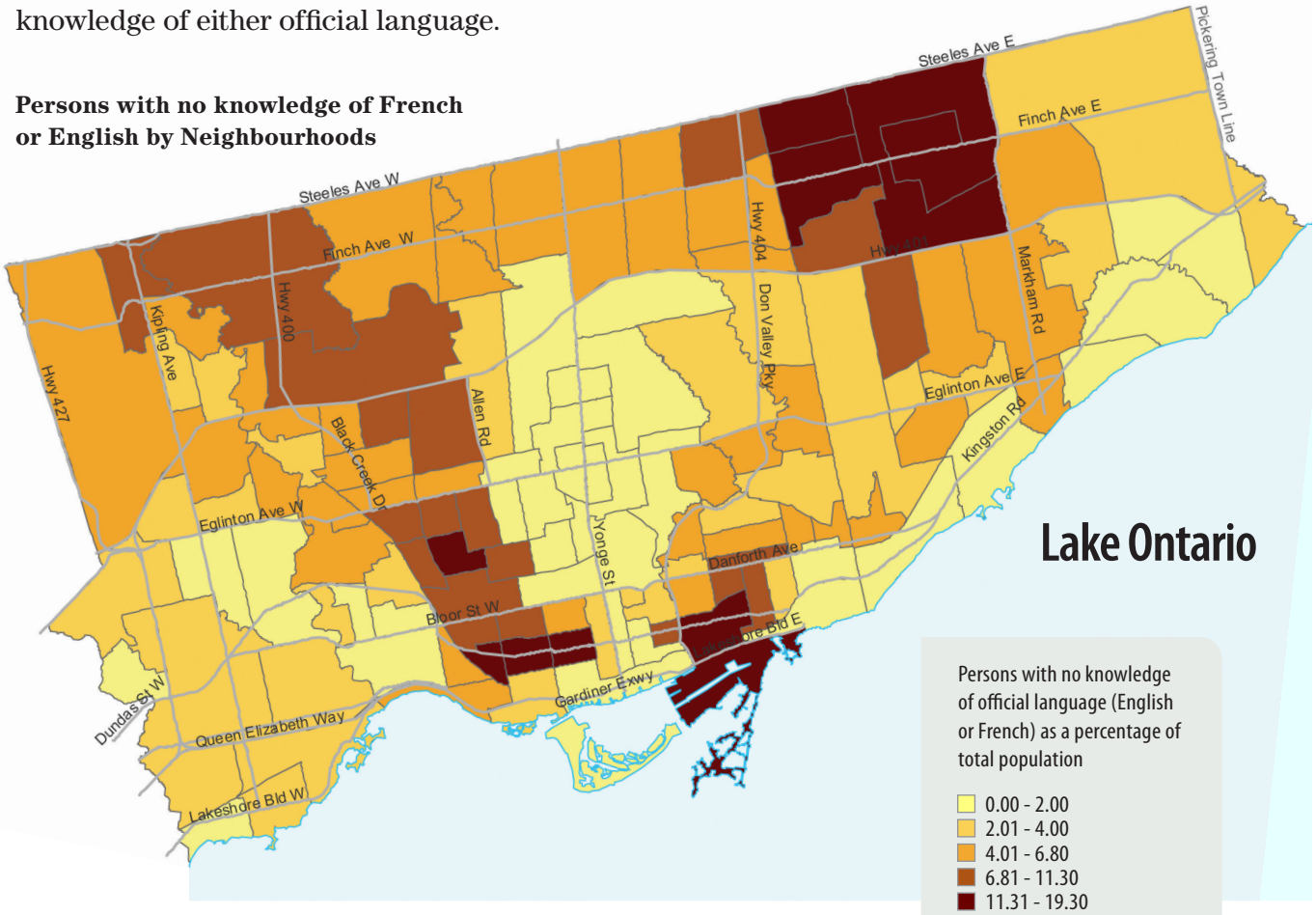
170 languages and dialects are spoken in Toronto. While they contribute to the wonderful diversity of the city, newcomers face barriers to care, particularly if they don't speak English. Today, 4.5 per cent of the population reports no knowledge of either official language.

Francophones in the city of Toronto



Source(s): Statistics Canada, 2006 Census of Population

Persons with no knowledge of French or English by Neighbourhoods



Data Source: Statistics Canada, 2006 Copyright©2009, Toronto Community Health Profiles Partnership: Not for commercial use

Top 10 Languages Spoken in Toronto after the Official Languages

1	Italian	6	Spanish
2	Chinese languages	7	Tagalog
3	Cantonese	8	Urdu
4	Punjabi	9	Tamil
5	Portuguese	10	Polish

Health Facts of TC LHIN Residents

Two thirds of Toronto Central LHIN residents say they have very good or excellent health; the highest proportion in the province. Although this proportion decreases with age, the rate is relatively high even among seniors with 44 per cent rating their health as very good/excellent.

Three out of four residents report very good or excellent mental health.

A total of 89 per cent of TC LHIN residents report having a regular medical doctor; lower than most other LHINs.

In terms of lifestyle, approximately 18 per cent of LHIN residents are smokers and 17 per cent are heavy drinkers. The rate of overweight/obesity among adults is the lowest in the province (38 per cent), however it is concerning that half of the people living in the TC LHIN are physically inactive.

Chronic Diseases

These health factors together with aging and others contribute to chronic diseases. Chronic conditions account for 6 out of 10 deaths and a quarter of the days spent in hospital. More people are being discharged from hospital for chronic obstructive pulmonary diseases (COPD) and diabetes, while the rate of hospital discharges for asthma and cancer are going down.

Chronic Disease in TC LHIN

- 33% of TC LHIN residents aged 12 years and older have a chronic condition;
- 14% have multiple conditions;
- 18% aged 65–74 years old have heart disease and, like the rest of Ontario, cancer is the leading cause of death;
- TC LHIN has the highest death rate associated with asthma, at nearly twice the provincial rate.

Mental Health and Addictions

One person out of five will experience mental health illness in their lifetime. Demand for mental health and addictions services in the LHIN is on the rise. Population growth may account for part of this increase but other factors are likely contributing to more people seeking help for mental health illness and addictions. Mental health illness and addictions is one of the highest health care costs and a significant reason for ER visits and readmissions to hospital.

Health Inequities

There are significant disparities in terms of access to health care and health status among TC LHIN residents.

Just over a quarter of the population is considered low income. A recent report by the Centre for Research on Inner City Health (CRICH) and the Institute for Clinical and Evaluative Sciences (ICES) suggests that lower income groups are exposed to greater health risk, have more complex health conditions and are not using preventative measures as much as those in the middle to high income groups.

Low income communities have higher rates of diabetes and mental health illness and addictions, but have fewer services close by.

Furthermore, a CRICH-ICES study involving the TC LHIN discovered that low income patients who tend to use local hospitals for mental health services are more likely to be ALC (meaning they are waiting in hospital beds because they cannot get access to care in another setting). They are more likely to use the ER for non-urgent reasons. Higher income patients, on the other hand, tend to be admitted for more same-day surgery. Toronto East General Hospital followed by St. Joseph's Health Centre see the greatest number of low income earners.

Gender and Health

Women make up more than half of all low income people and more than 65 per cent of all low income seniors. According to the Project for an Ontario Women's Health Evidence-based Report or POWER study, while men had an overall higher rates of diabetes than women in Ontario, women had worst health outcomes than men, including higher rates of other conditions including depression.

Language and Health

A recent American study concluded that patients with limited proficiency in English stayed longer in hospital when they were unable to communicate in their chosen language. The study also indicated that quality of care increases when a patient is able to communicate in their language of choice.

Sexual Diversity

Toronto has the highest number of lesbian, gay, bisexual and transgendered (LGBT) people in Canada. There are a variety of services for different parts of the LGBT community, including more services designed for LGBT seniors. However, gaps remain, particularly in long-term care. As they age many LGBT people are five times less likely to use health and social services for fear of discrimination. As they age, they continue to have diminished support networks and relocating to long-term care homes can be extremely stressful. Seniors living with HIV/AIDs face particular stigmatization in long-term care.

Refugee Health

Refugees are particularly vulnerable. Often refugees who lack health insurance are denied care when care is sought, and are discriminated against. As a result, these individuals tend to use the ER, and are sicker by the time they receive care. There is widespread concern that the federal government's changes to the Interim Federal Health (IFH) Program, a program that provides temporary health benefits to refugees is very harmful to a group of that already has significant health risks.

Meeting the Health Care Needs of the Most Complex, High-Needs Patients

A small number of people account for the lion's share of health care use and costs. In fact, 1% of the population accounts for 34 per cent of

health costs and 5% of the population accounts for 50 per cent of costs. The health care system often fails these high needs populations. Substantial savings can be achieved by more effective, efficient management of these patients. Just a 1 per cent reduction in their cost of care translates into $100 million in Ontario.

Who are the people in these groups and what do they need?

There is considerable work going on in the TC LHIN to better understand the patients in these groups, their needs and how we can do a better job collectively with their health care. Here are some important facts about these groups.

The 1% High-Needs, Highly Complex Patients

The people within the "1%" group are seriously ill. There is a low likelihood of being able to prevent or slow their disease. Some are at the end stage of life.

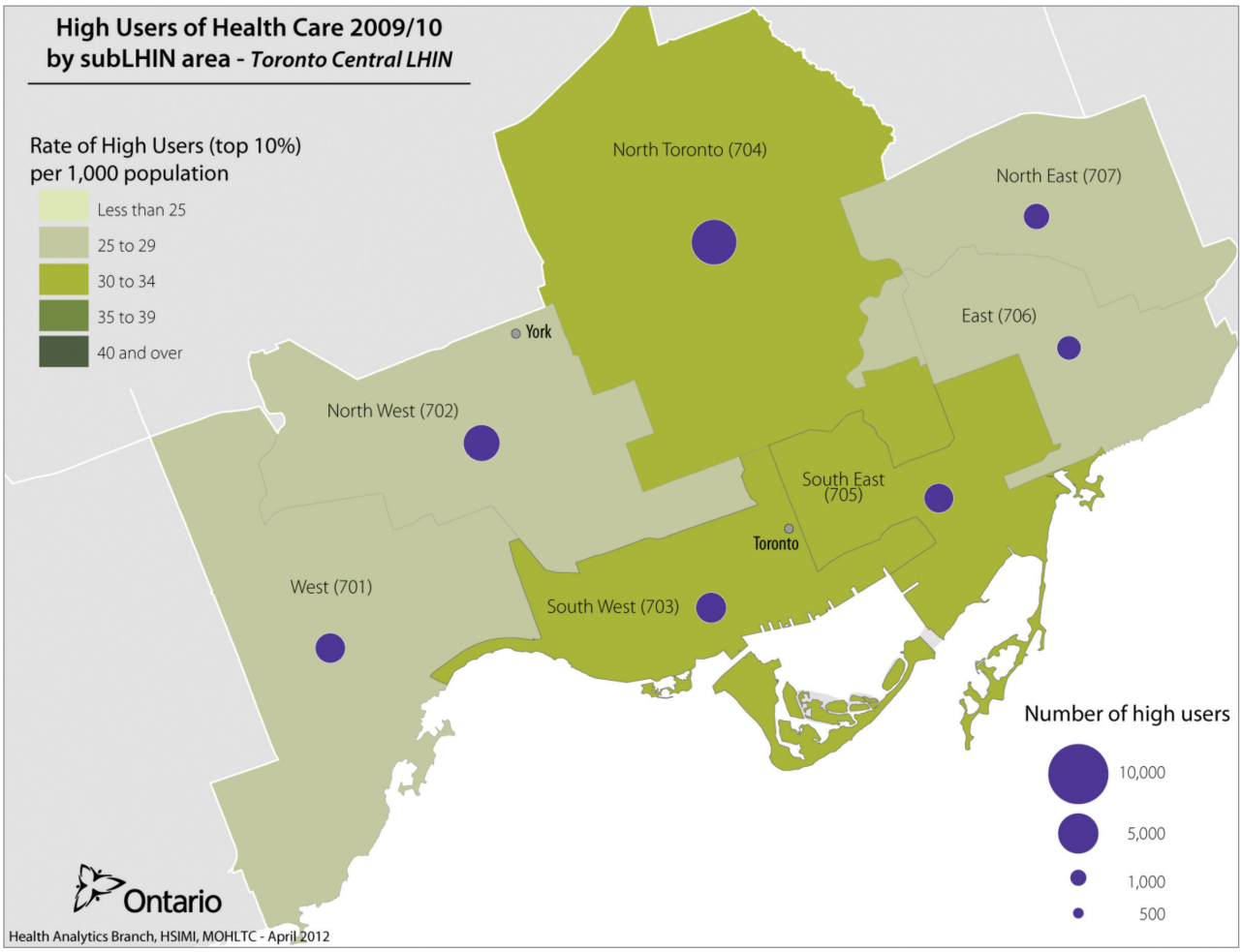
The population has special needs and requires their health, social and community services to be tightly coordinated. It is estimated that 44 per cent of this group are over the age of 65 and 23.8 per cent are middle-aged which includes a proportion of whom are living with degenerative diseases. Of the 8.7 per cent of patients aged 1-17 years old, older teens face the challenge of moving from the children's system to the adult system. A proportion of the infants in the "1%" group are receiving highly specialized care (many from the Hospital for Sick Children) and could not be safely cared for at home or another location.

Within the 5% population – the people who require the highest proportion of healthcare resources – there are many who are at risk of hospitalization, but are able to maintain independence and stay healthier with the right services and support.

Of this group of patients, those who were admitted to hospital, 29 percent were designated Alternate Level of Care at some point during their stay and remained in hospital an average of 59.3 days – 5 times longer than the average person. This indicates that currently many are not receiving the supports they need and are not in the 'right place of care.'

Patients in this group tend of have multiple chronic diseases and use multiple parts of the health care system. These patients require ongoing primary care to prevent their diseases from progressing. Nearly 70 per cent of seniors in the 5% group receive home care. Caregivers play an indispensable role in helping these individuals with their daily needs. Patient self-management programs can improve their health and quality of life.

The following shows where individuals in the 1% and 5% groups live in the TC LHIN:



Who Comes to Toronto Central for Care?

A large number of people come from other LHINs to TC LHIN for their care. Some choose to seek care here and others are referred for special services.

Downtown Toronto is the largest urban workforce in Ontario with 2.4 million commuters coming into the city each day largely from the GTA. Many people choose to access health care services near their workplace.

As well, a number of TC LHIN hospitals provide specialized services not offered elsewhere in the province. More than half the patients in local hospitals are from out of town, and 41 per cent of alternate level of care (ALC) patients discharged from hospitals in the city live in other LHINs.

The people who travel into the TC LHIN reflect the changing face of their communities. Some GTA communities have the highest rate of immigration in Ontario, with Central West LHIN which includes Brampton and Caledon accounting for the highest immigration rate in Ontario at 9.5 per cent.

TC LHIN Scorecard

Comparing 11/12 to 10/11

Grouping	MLPA Indicator*	11/12 compared to 10/11
Emergency Room/ Alternate Level of Care	Percentage of ALC days	Met target
	90th Percentile ER length of stay for admitted patients	Right Direction
	90th percentile ER length of stay for non-admitted complex patients	Right Direction
	90th percentile ER length of stay for non-admitted minor/ uncomplicated patients	Right Direction
Surgical Wait Times	90th percentile ER length of stay for non-admitted minor/ uncomplicated patients	Met target
	90th percentile wait times for Cardiac Bypass	Right Direction
	90th percentile wait times for Cataract Surgery	Wrong Direction
	90th percentile wait times for Hip Replacement Surgery	Wrong Direction
	90th percentile wait times for Knee Replacement Surgery	Wrong Direction
Diagnostic Wait Times	90th percentile wait times for MRI Scans	Met target
	90th percentile wait times for CT Scans	Wrong Direction
Excellent Care for All/ Quality	Readmission within 30 Days for Selected Case Mix Groups (CMGs)	Right Direction
Mental Health and Substance Abuse	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions	Met target
	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions	Unchanged (0.03% increase)
Access to Community Care	90th Percentile Wait Time from Community for CCAC In-Home Services – Application from Community Setting to first CCAC Service (excluding case management)	Unchanged

Definition of the 90th Percentile: The amount of time for 90% of patients to complete their visit (Example: 90% of patients completed their ED visit within 48 hours)

* *MLPA refers to the Ministry/LHIN Performance Accountability Agreement. This is the performance target that the Ministry of Health and Long-Term Care and the TC LHIN agreed upon.*

Alternate Level of Care

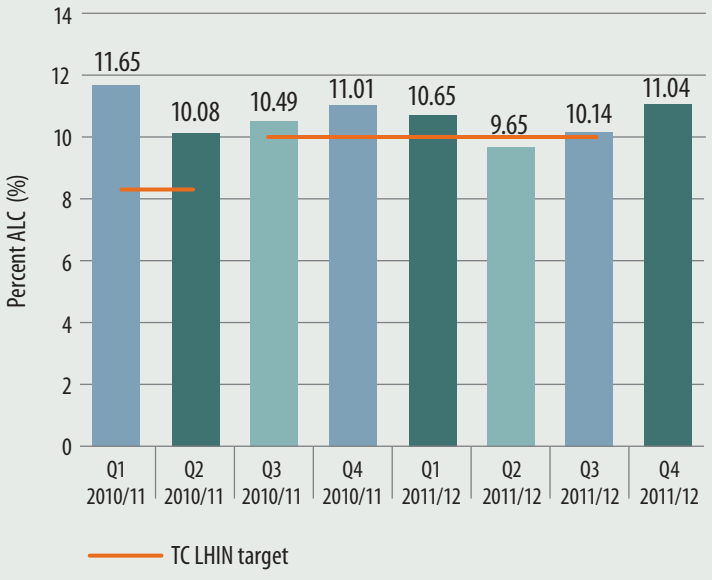
What's Important?

ALC rates continued to improve and the TC LHIN reached the lowest rate event in 2011/12

TC LHIN finished the 11/12 year with an ALC rate of 10.36% which was only 0.36% above our target.

With one of the lowest long-term care bed capacity for seniors, this measure continues to be a challenge.

TC LHIN Percent ALC Days 2010/11 - 2011/12



% of ALC Days

Reflects the number of all acute inpatient days when acute patients could be treated elsewhere. For example: rehabilitation, complex continuing care, home and long-term care relative to total inpatient days for the quarter.

TC LHIN Scorecard

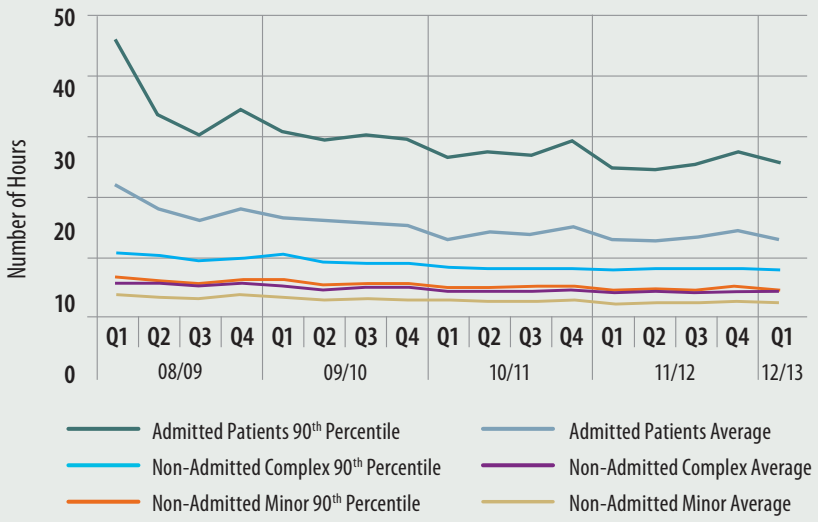
Emergency Room Visits: 90th Percentile ER Length of Stay

What's Important?

A large majority of people in the TC LHIN who visited the ER last year were treated, sent home or admitted to hospital within the target wait time.

TC LHIN was over target for all 3 Emergency Visit measures in 11/12 however has made improvement across all 3 since 10/11 and is continuing to trend positively.

TC LHIN ED Visit: Length of Stay by Patient Type



ER Length of Stay

Defined as the time from registration date/time or triage date/time (whichever is earlier and valid) to the date/time the patient was admitted to an inpatient bed. While in ER the patient may be receiving treatment, medication, undergoing tests, seeing clinicians or waiting for a bed.

How Long Did it Take for 10 patients to be treated in the ER between Jan-Mar 2012?

Admitted Complex

9 were treated in less than 27.7 hours

1 waited longer than 27.7 hours

Non-Admitted Complex

9 waited less than 8.15 hours

1 waited longer than 8.15 hours

Minor Uncomplicated (non-admitted)

9 waited less than 5.1 hours

1 waited longer than 5.1 hours

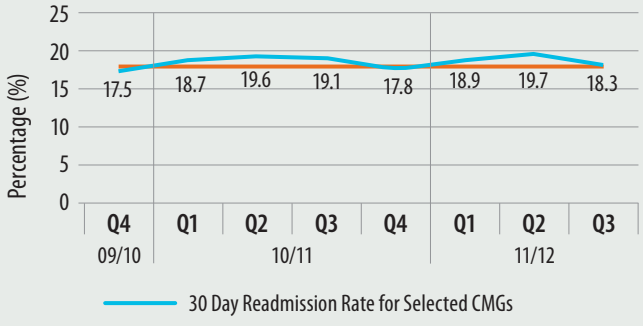
Extracted from Access to Care, September 12, 2012

Readmission Within 30 Days: Selected Case Mix Groups

What's Important?

TC LHIN has the highest readmission rate of all LHINs, at 18.32%. While some degree of readmission is expected TC LHIN is focusing on improvements on this front in 12/13 and 13/14.

Readmission within 30 Days for Selected Case Mix Groups (Q3 2011/12)



Data Source: Discharge Abstract Database (DAD), MOHLTC, SAS Server, 2011/12 Interim Data Set, Extracted July 2012.

Readmissions

Represents the proportion of patient discharged for the following conditions or "Case Mix Groups": Stroke, Chronic Obstructive Pulmonary Disease and Congestive Heart Failure, and Cardiac for patients >40, and pneumonia, diabetes and Gastrointestinal conditions for patient of all ages who were admitted to hospital within 30 days on an unplanned or urgent basis.

What is a repeat Re-admission?

Discharge From TC LHIN Hospital unit for 1 of the 7 conditions

Unplanned or urgent admission to hospital

Financial Picture – 2011/12

2011/12 Expenses

Health Service Providers' Operations Funding	$4,462,702,232
Toronto Central LHIN Operations Funding	$7,016,227
LHIN Shared Services Office (LSSO)	$5,096,272
LHIN Collaborative (LHINC)	$1,024,558
Targeted Funding	$44,172,077
French Language Health Services and Planning Entity	$674,713
Total	$4,520,713,579

The main types of expenditures in the Toronto Central LHIN:

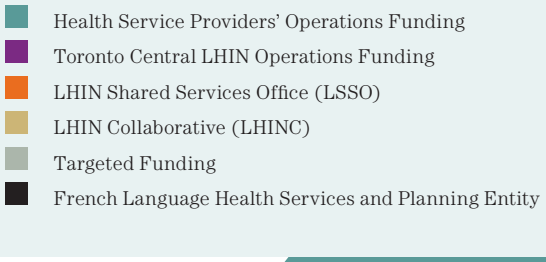
HSP Operations – These are funds provided by the TC LHIN to health service providers for day-to-day operations and patient care/services.

Targeted Funding – These are funds that are targeted to different programs and initiatives to improve local health services.

Toronto Central LHIN Operations Funding – This is funding to operate the Toronto Central LHIN organization.

The Toronto Central LHIN is also accountable for the operational budget for the services that are shared among all 14 LHIN organizations – LHIN Shared Service Office (LSSO) and LHIN Collaborative (LHINC).

Toronto Central LHIN Expenses



The Road Ahead

This past year the LHIN put in place a new Strategic Plan that sets the course of action in the health care system over the next two years.

The Plan is designed to improve quality of care and health outcomes and to put the system on a sustainable footing for the future. In developing the Plan we started with the patient - by getting the facts about their health care, and by seeking feedback directly from patients about how to improve the system.

In two years, we aim to have a more integrated health care system that is responsive to patients' diverse needs and provides for a better experience as people move across the system. Patients and caregivers will be more involved and have better information about their care and be able to influence decisions about their care.

The TC LHIN will set clear metrics that we will tell us whether we are achieving these improvements.

The TC LHIN and health service providers will be taking action in five key areas:

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

These patients are in hospital unnecessarily when they could be at home or in the community with the right supports. They have preventable health problems. We know we can do more collectively to improve their quality of life and outcomes.

We will focus on four particular groups in this 1% population – frail seniors, palliative care patients, medically complex children, and people with serious mental illness and addictions.

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

In addition to people with mental health and addictions and frail seniors, we will develop programs for people with multiple chronic conditions.

The goal is to provide these patients with effective disease management in their communities. If well managed, these individuals will be healthier, more satisfied, and need fewer resources.

» Improving the Patient Experience.

The aim is to design services based on what people need and what they say is important to them. Over the next few years, all health service providers will begin to measure and report on how they are improving the patient's experience with health care. We will start this year by working with patients and those who deliver health care to determine the most meaningful way to measure the patient experience.

We will also be going into communities including St. James Town and Weston Mount Dennis to hear directly from local residents about their health concerns and the changes they would like to see.

Deliver value and sustainability through efficient use of resources.

This priority is about making the resources we have in the system go further. It is about working smarter, together.

Stroke and hip and knee rehabilitation services will be redesigned to better serve patients in 2012/13. Through reorganizing and enhancing hospital and outpatient services, patients will recover sooner, improving the patient's health and experience.

The TC LHIN is leading a local strategy to improve the quality of wound care across the city. Unmanaged wound care is both preventable and enormously expensive, costing about $74 million a year in the TC LHIN.

We will be implementing a Primary Care Action plan this year. The outcome: more Toronto residents will have a primary care physician, more people will be seen by a primary care practitioner soon after being discharged from hospital, and primary care providers will receive full and relevant information about their patients when they leave hospital.

At the same time, the TC LHIN will be making targeted investments in community health services and working with agencies to develop new approaches to serving a growing group of seniors with more complex health needs.

Sustain our Gains.

As a system we have made progress in key areas such as increased coordination and access to community supports, home care, mental health and addictions services and lower ER wait times. We will sustain the improvements, while we work to raise the bar in other areas of health care.

Toronto Central **LHIN**

Report to the Community

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Ontario
Local Health Integration Network