Toronto Central **LHIN**

Partners in Action

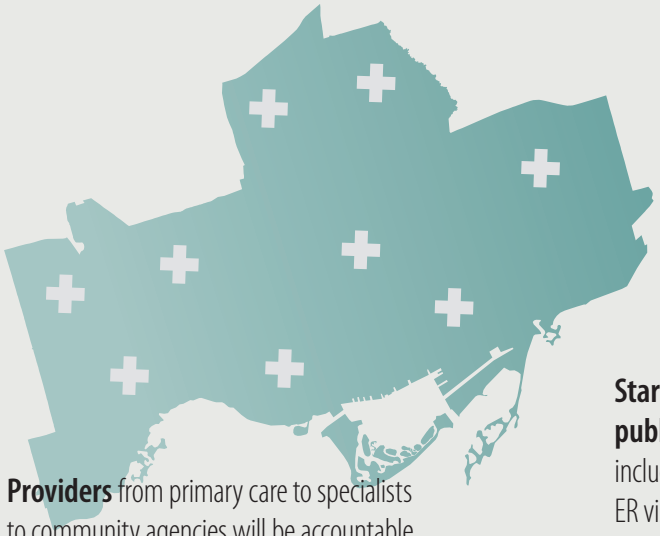
Our Community, Your Health

Report to the Community 2012/13

Transforming the system for your health.

Ontario
Local Health Integration Network

Roundup of Health Care Improvements in the Toronto Central LHIN



Providers from primary care to specialists to community agencies will be accountable for providing services to and improving outcomes of people in their area; **first four launched in 2012/13.**

9 Health Links being created in TC LHIN to improve people's access to health services in their communities.

Starting in 2013, the TC LHIN will report publicly on providers' performance including: hospital readmission rates; repeat ER visits for non-emergencies; referrals and admissions to hospitals.

100% of hospitals, long-term care homes, community support and mental health and addictions agencies, community health centres and the Community Care Access Centre have committed to **common quality indicators** in their accountability agreements.

TC LHIN invested **$22.4 million** more in community health

7% funding increase for community mental health and addictions and a **4% increase** for community support services.

18 new or expanded services for older adults with high needs; people with disabilities; Aboriginal people; people with mental illness and addictions; and medically complex children.

10% more people without a primary care provider were connected to a family physician through Health Care Connect since October 2012. **17% more vulnerable patients** were connected to primary care.

All hospitals are starting to collect vital demographic information from patients.

This first-in-Canada program will allow us to measure and address health disparities related to income, race, ethnicity, language, sexual orientation and other factors.

17 hospitals and **15** community agencies offer **phone interpretation** to more non-English speaking clients through Language Services Toronto. **37,000 minutes** have been delivered so far; hospital interpretation rates are down by as much as **80%**

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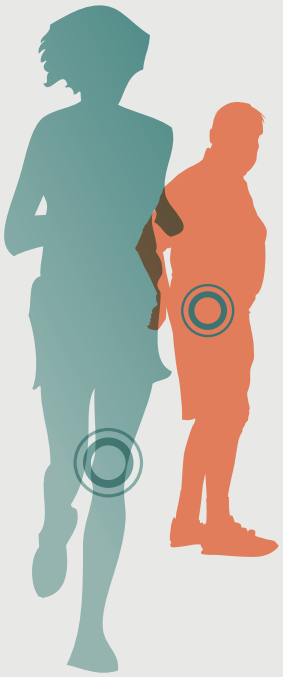
742 people with mental illness and addictions are connected to supportive housing, case management and others services using one phone number –

Access1.



Patients are going home sooner after hip and knee replacement. The number of patients discharged home for ambulatory rehabilitation increased from **64%** to **81%** within a year.

Behavioural Support for Seniors has supported **468 older adults** so far.

The Behavioural Support Unit at Baycrest is providing a safe environment and specialized care for people with the most serious behavioural challenges. **Over 1,560 providers** have been trained to care for the growing number of people with behavioural symptoms related to Alzheimer's and other age-related conditions.

1,025 visits →
by Outreach Teams
to seniors.

Message from the Board Chair and Chief Executive Officer

The Toronto Central Local Health Integration Network (TC LHIN)'s initiatives and their positive impacts on our community are a direct result of strong partnerships. This Report to Community, entitled Partners in Action: Our Community, Your Health, brings you an update on projects that the TC LHIN undertook in 2012/13 and the collaboration amongst providers that enabled them.

Priorities identified in the newly developed 2013-2016 Integrated Health Service Plan (IHSP), set TC LHIN's course of action over the next three years to achieve a more person-centred, high-quality health care system. These priorities connect our work on the ground to our Strategic Plan and to the Ministry of Health and Long-Term Care's Action Plan for Health Care. By working in partnership with health care providers and our community we are able to strive towards – and achieve - one singular goal: transforming the system for your health.

Though Toronto is an enviable hub of highly specialized health sciences, a gap remains between local residents and their primary care services. In fact, the TC LHIN region has the highest proportion of adults without primary care in the entire Greater Toronto Area. Without access to primary care, people rely more heavily on acute care and can develop more complex health issues, eventually causing strains on them and the system. As health care system planners, the TC LHIN led the Primary Care Strategy last year to improve access to primary care services.

Health Links in the TC LHIN had a commendable launch and are already realizing positive benefits to primary care. In 2012/13, four of the nine planned Health Links were established and began work to coordinate services and ultimately address the key problems identified in the Primary Care Strategy. The Health Links have begun work by focusing first on strengthening and improving care integration for complex clients (individuals with complex health issues who use the health system the most). This is just the beginning and soon, all of the nine Health Links will be providing coordinated care to patients, faster and better services and smoother transitions across the system.

The TC LHIN acknowledges that effective planning for the health care system requires input from the people who live in the neighbourhoods that comprise our LHIN. That's why the TC LHIN invested in several community engagement projects in 2012/13 to include the opinions and insights that matter the most – yours.

Mount Dennis is a diverse Toronto neighbourhood and many people there have unique health needs. In partnership with Patient Destiny, a patient-focused advocacy group, the TC LHIN met with residents several times, in various settings to ensure all voices were heard, including ones that previously had not been considered. A comprehensive report of the findings and recommendations generated from those meetings highlight how improving health services could improve specific health outcomes as well as overall quality of life for Mount Dennis residents.

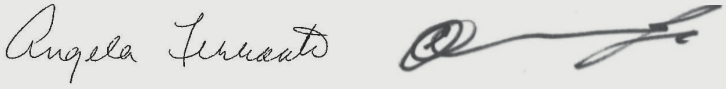
We witnessed various accomplishments in 2012/13, but some of our performance indicators are telling us that we aren't where we need to be if we truly want to transform the system.

The number of hours that admitted patients are spending in the ER has increased and gone outside of the provincial's target range. However, the continued decrease in time spent in the ER by non-admitted patients whose needs are considered minor, indicates that hospitals are committed to reducing the length of stay for all types of patients. The TC LHIN acknowledges the importance of treating patients in the ER effectively and part of that is making sure that they are transitioned quickly and seamlessly to the next most appropriate setting of care.

As we move into a new year, we strongly believe that by focusing our work at the community level and on complex and at-risk populations, we can affect multiple parts of the system simultaneously – including acute care. Health Links, coordinated access portals and public reporting are just some of the very different projects that we are working on – projects that will have a demonstrable impact on the quality, safety and cost effectiveness of the system.

We encourage you to read further into this report so you can better understand the role of the TC LHIN in the community and learn more about how we are focusing on our priorities and in so doing, achieving our goals.

The TC LHIN Board of Directors and staff extends gratitude to the health service providers and all of the partners from the health care system and the community for their ongoing dedication and commitment to working together to improve and transform our health care system, for today and into the future.



Angela Ferrante
Board Chair

Camille Orridge
CEO

The Neighbourhoods and Communities of the TC LHIN

Toronto Central Local Health Integration Network (TC LHIN) is Ontario's only completely urban LHIN. It is diverse in every respect – socially, culturally and economically. It is also unique in that it has relatively high population density. This density is increasing through intensification, reflected in the influx of new condo developments. TC LHIN is also an area of neighbourhoods, each with its own distinct population mix, character and challenges. Neighbourhoods in the city are dynamic and continually changing. As neighbourhoods transform, so do the health needs of the residents who live in them.

TC LHIN Population Facts

- 2.6 million people live in Toronto, the fifth largest city in North America. 1.15 million people live within TC LHIN.
- 2.4 million daily commuters come into Toronto.
- 54% of patients in TC LHIN hospitals and 55% of patients who see TC LHIN family physicians reside in other LHINs.
- An estimated 32% of the population is 22 to 44 years old and 14% is aged 65 years and older. Seniors will account for 14.8% of the LHIN's population by 2016.
- 41% of residents are immigrants, 8.3 % of whom arrived in Canada between 2001 and 2006.
- 170 languages and dialects are spoken in Toronto and 4.5% of the population reports no knowledge of either official language.
- There are 53,000 Francophones in Toronto (9.2 % of Ontario's Francophone population). Many are recent immigrants and/or visible minorities.
- Toronto has one of the largest and most diverse Aboriginal populations in Canada. Approximately 1.5% to 2% of TC LHIN residents are Aboriginal and 50% of the Aboriginal population is under the age of 25.
- Just over one quarter of the population is low income.
- Toronto has the highest number of lesbian, gay, bisexual and transgender (LGBT) people in Canada.

Health Inequities

According to a report by the Centre for Inner City Health (CRICH) and the Institute for Clinical and Evaluative Services (ICES), lower income groups have greater health risks, more complex health conditions and use the local ER for mental health services and are most likely to go to the ER for non-emergencies.

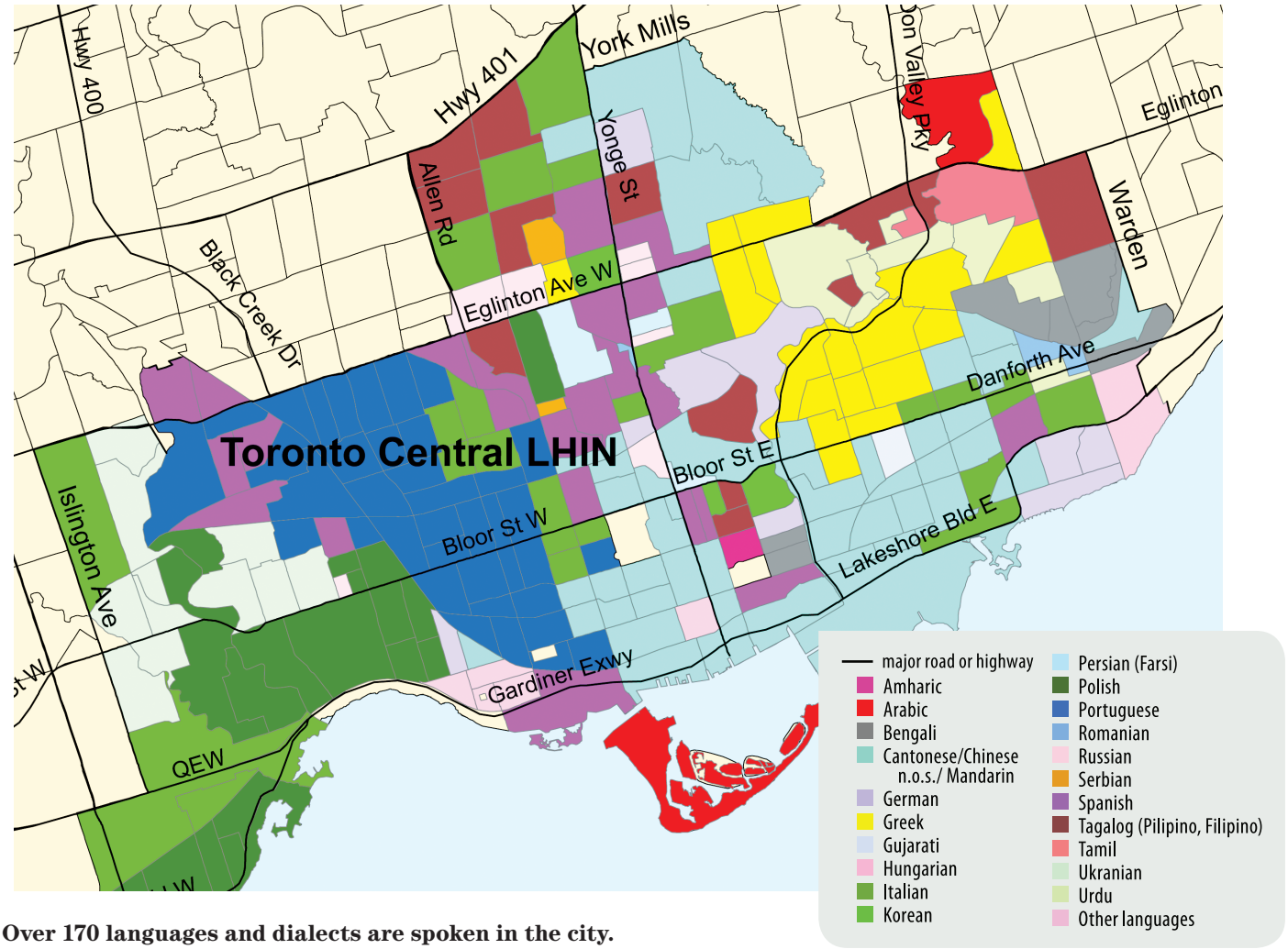
According to the 2006 Aboriginal Peoples Survey, over half of First Nations (58 percent) and Métis (55 percent) adults living in Toronto reported that they had been diagnosed with at least one chronic condition. Diabetes in the Aboriginal communities is three to five times higher than the general population.

Higher needs neighbourhoods also tend to have higher rates of diabetes than more affluent areas.

32.6% of TC LHIN residents over the age of 12 have chronic conditions including:

- Asthma 8%
- Diabetes 5.9%
- Heart disease 4.3%
- High blood pressure 14.1%
- COPD (over the age of 35) 2.8%

At 25,948, TC LHIN has the third highest rate of ER visits related to mental health/substance abuse.



Over 170 languages and dialects are spoken in the city.

Five percent of people who use health care services, or approximately 22,500 people in the TC LHIN, use over 50 percent of the hospitals' and Community Care Access Centre (CCAC)'s resources and they are known as "complex clients" which include frail elderly, adults with multiple chronic conditions, medically complex children and palliative clients.

Health Services in TC LHIN

Toronto Central LHIN has a highly diverse health care system.

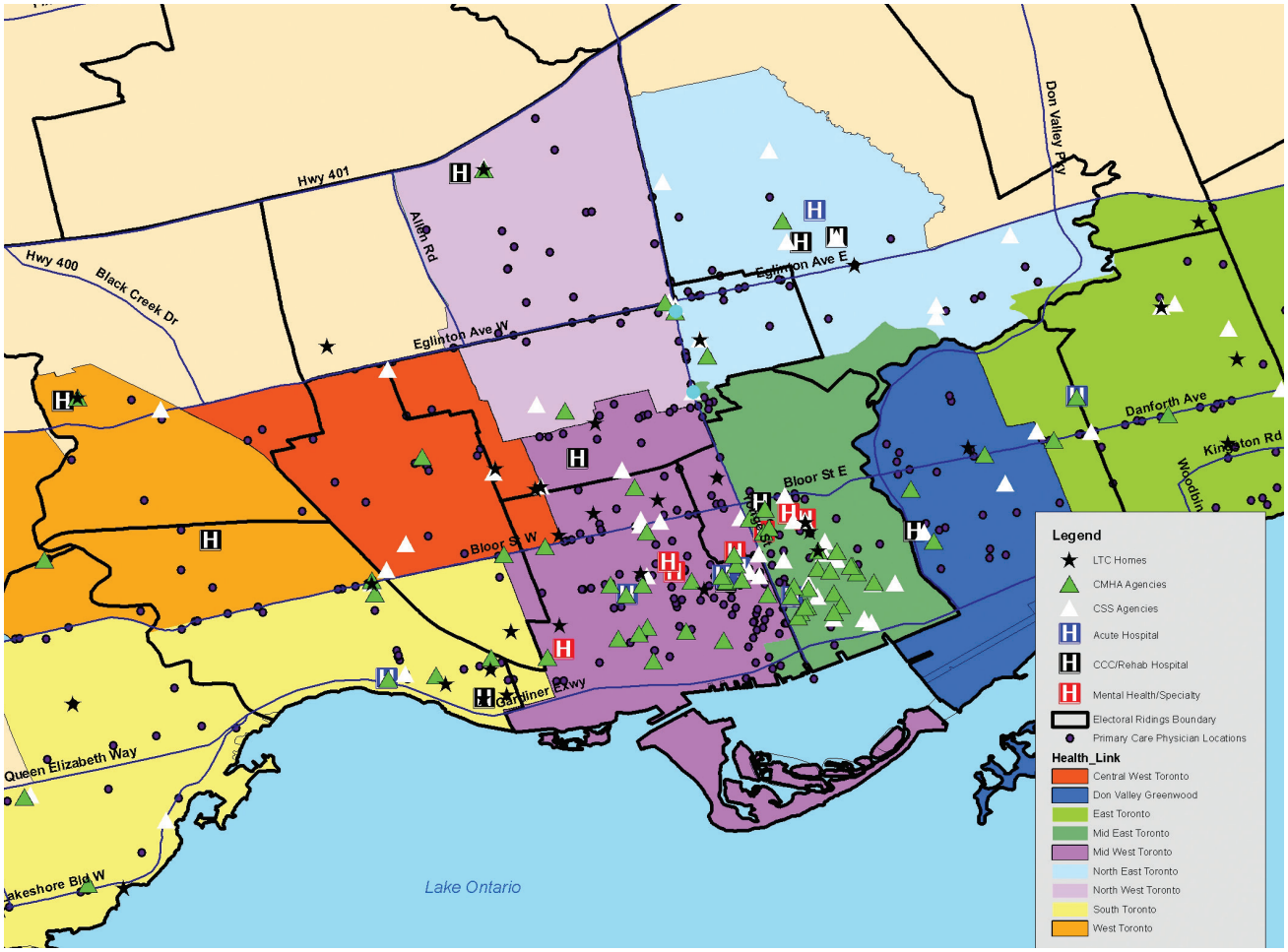
TC LHIN's 17 hospitals include – five acute care, two community hospitals, three specialty and seven rehabilitation and complex continuing care hospitals. It is home to most of Ontario's academic health sciences centres that provide highly specialized services to people across Ontario, as well as being vital medical research and education hubs. World renowned hospitals, such as The Hospital for Sick Children, Princess Margaret, Holland Bloorview Kids Rehabilitation Hospital and the Centre for Addiction and Mental Health, provide services that are not available anywhere else in the province. Pioneers in their own right, TC LHIN hospitals are also working together to improve service delivery and outcomes in areas including stroke, hip and knee replacement rehabilitation, cardiac and vision care.

The TC LHIN also funds 154 community-based health agencies that provide services to particular neighbourhoods and populations such as seniors, people with mental illness and addictions, people with disabilities, children, families and newcomers. Their budgets range from under $300,000 to over $85 M a year from TC LHIN and other funders.

TC LHIN Health Services at a Glance

- 17 community health centres providing an estimated 368,700 primary care face-to-face visits.
- 17 hospitals totaling 2.19 million patient days per year.
- 1 Community Care Access Centre providing an estimated 3,458,660 visits/hours of care and case coordination.
- 37 long-term care homes accounting for 5,966 beds.
- 67 community support services providers providing an estimated 848,037 visits.
- 69 community mental health and addictions agencies provide an estimated 1,132,115 visits.

The TC CCAC had an annual budget of $214 M. As you can see in the map below, services in our area tend to be concentrated in certain pockets. The TC LHIN works with health service providers to assess whether we have the right services in the right places to meet the needs of the population.



Update on Health Care in TC LHIN

Our goal is to create a person-centred health care system. This means designing the health care system around what the population needs. While this may sound simple, the reality is that needs and expectations have changed faster than the health care system. People receive excellent care from individual providers and for specific treatments and procedures. However, we do not have a system that puts patients at the centre. The quality of care can and must be better.

To change this we need to redesign how we provide health care. This will require all people and organizations involved in health care sharing the same goals, making decisions that are informed by the best evidence, and involving patients, clients and community members as partners.

The following highlights the progress that has been made and the challenges we are tackling to improve health care in the TC LHIN.

Making it Easier to Access Services, Close to Home

Primary Care

Family physicians and other primary care providers are people's gateway to the health care system.

However, many people in the TC LHIN do not have a primary care provider and some who do have a family doctor cannot get an appointment when they need medical attention.

There are **1,126 primary care physicians** in the TC LHIN practicing in a variety of settings including multidisciplinary teams (such as Community Health Centres and Family Health Teams) and solo practices. Most physicians are not operating as part of a team. Another challenge is that primary care providers are not well connected to hospitals and community health services and have difficulty referring patients to specialists and other services.

The **TC LHIN has the highest proportion of adults without primary care in the GTA.** Our region also has the lowest percentage of patients who visit their family physician within seven days of discharge from hospital.

This is in part because over 50 percent of the primary care services in the TC LHIN are provided to people who live across the GTA and local family physicians are less able to take on the residents in their surrounding communities. Many of the city's family physicians also practice part-time, and an estimated 41 percent are over the age of 59 and are considering retirement in the next ten years.

In 2012/13 the **TC LHIN led a strategy to improve access to primary care services** in the LHIN.

There are many excellent primary care providers in Toronto that are providing comprehensive care to many thousands of patients and families. Community Health Centres, the Sherbourne Health Centre's Health Bus and groups like Inner City Health Associates are leaders in serving vulnerable populations. The **TC LHIN's Primary Care Strategy** builds on these strengths while improving how services are coordinated as people move between primary care, specialists and other providers.

Some neighbourhoods in the TC LHIN that have significant poverty and many new immigrants have little or no primary care in their communities. Primary care tends to be clustered in certain parts of the city such as the downtown core. Neighbourhoods, including St. James Town and Regent Park, that have a relatively high proportion of primary care providers close by have the highest number of people who are readmitted to hospital soon after being discharged, as well as ER visits for non-urgent reasons. This indicates that some people who live in these communities are not receiving adequate primary care and other services in their communities.

"South of Lawrence Avenue, there is a stark lack of medical supports, meaning that people must travel for prescriptions. The few resources that are available are limited, not accepting patients or people are not aware of these services. For those who choose to forgo access rather than travel, small ailments can become much larger before they are addressed and regular check-ups can be neglected."

The Community We Want: 2012 Weston Mount Denis Survey Results, Learning Enrichment Foundation

The **TC LHIN undertook a review of primary care in the region and sought advice from over 250 people** – experts, primary care providers, health care organizations, patients and community leaders. A blueprint for improving primary care was announced in December 2012, with an initial focus on integrating primary care with hospital, home and community care within local or "sub-LHIN" areas for the most complex patients.

Over the past year the TC LHIN's Primary Care Physician Advisors worked with primary care providers across the LHIN to find ways to connect people without a family physician to primary care, focusing on high-needs patients.

These efforts are working.

Ten percent more people who were without a primary care provider were connected to a family physician through Health Care Connect since October 2012. And 17 percent more vulnerable patients connected to primary care during this time.

Health Links

From a bird's eye view, Toronto is a large expanse of concrete, bricks and roads, dotted with numerous green spaces. It could be any other major urban metropolis. But at street level, Toronto is made up of distinct local areas. In December 2012, the Ministry of Health and Long-Term Care announced the creation of Health Links to coordinate health services in local areas. Health Links are groups of providers that coordinate services for people who live in their area. Health Links are the key means to address the problems identified by the TC LHIN's primary care strategy. There will be nine Health Links in TC LHIN.

The first four Health Links have been established: **Mid West Toronto, Don Valley Greenwood, North East Toronto and East Toronto.** By 2015, all nine will be fully implemented.

Central West Toronto

- Lowest number of seniors living alone (22.3%).
- Highest rate of people who speak a language other than English at home.
- Most single parent families (76.5% couple families).
- Lowest number of health service providers.

West Toronto

- Fewest number of primary care physicians in the TC LHIN.
- Very high proportion of new immigrants, youth and young adults (especially in the Weston-Mount Dennis area).

South Toronto

- Highest number of seniors living alone (6,525) and the greatest number of older adults who are the highest health care users.
- Some neighbourhoods have few community supports and mental health services close by.

North West Toronto

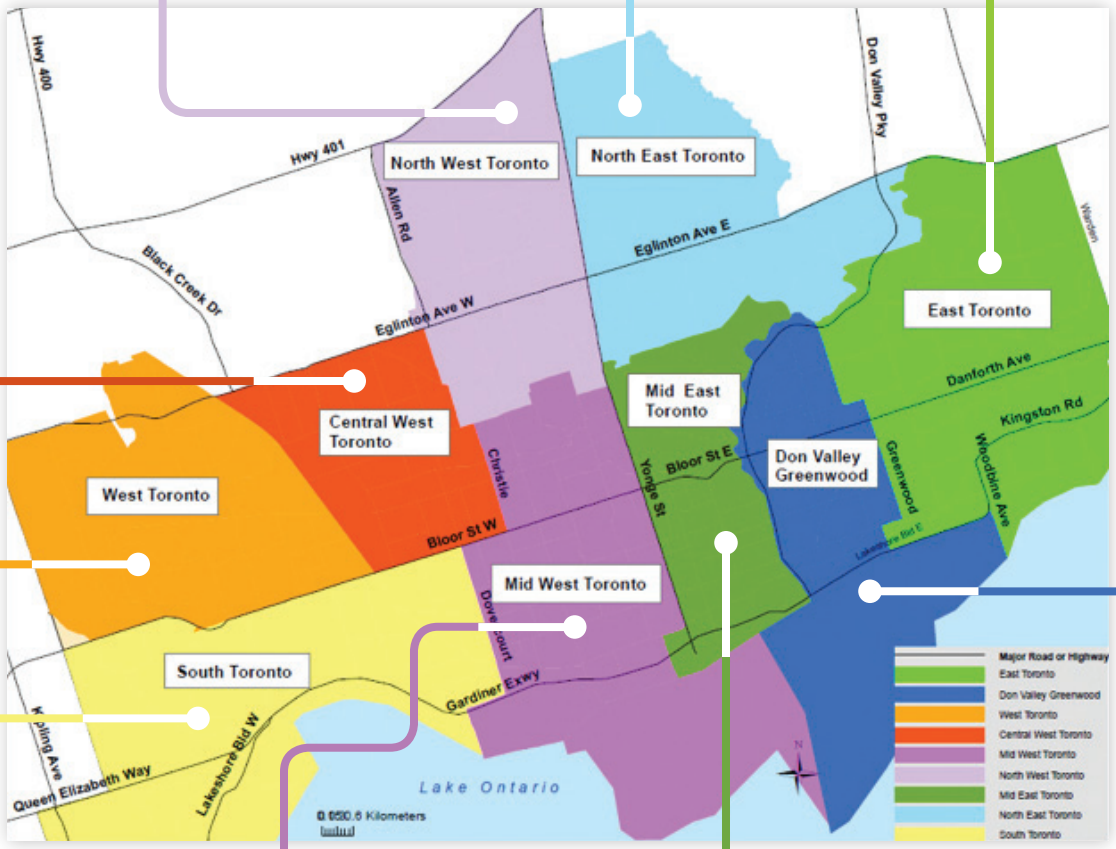
- Largest population of seniors over 85 years old.
- Highest proportion of English speakers (87.2%).
- Lowest hospital rates for people over 45 years old.

North East Toronto

- Significant contrasts in the populations: from the affluence of Bridle Path and Leaside to the high density, low-income communities of Thorncliffe Park and Flemingdon Park.
- Over 30,000 residents, primarily new immigrants, living in more than 34 buildings in Thorncliffe Park.
- Flemingdon Park also has a high rate of immigrants.

East Toronto

- High number of seniors live in this area but also has the highest number of youths aged 0-19 years.
- Serves a number of low income and priority neighbourhoods.



Mid West Toronto

- Greatest concentration of primary care physicians in TC LHIN.
- Home to most of the largest academic health sciences centres.
- Nearly half of patients receiving care come from outside the TC LHIN to access the specialized services.
- Highest rate of family physicians using an electronic medical record.

Mid East Toronto

- High percentage of immigrants with 20% of the overall population having no knowledge of English or French.
- Higher than average rates of mental illness, addictions, homelessness and street-involved people.
- Neighborhoods with the highest readmission and hospitalization rates.

Don Valley Greenwood

- Population made up of young, professional and working-class neighbourhoods.
- There is an above average rate for people visiting ER for non-emergency needs who need another type of care.

What Health Links Mean for Patients

- Faster care and spend less time waiting for services and referrals.
- Same day/next day access to their primary care provider.
- Smoother transitions through the health care system.
- Support from a team of health care providers at all levels of the health care system.
- Care that responds to their specific needs.

Health Links will start by focusing on those who have the greatest needs and use the most health services. Complex patients need all providers to work as a coordinated team. However, too many of these individuals encounter obstacles as they move from one service to another.

Too often they suffer avoidable problems such as medication errors, infections and debilitating pain. Many are in and out of hospital or prematurely admitted to long-term care when it would be better for them – and they would prefer – to receive care in their communities and homes.

High quality care costs less than poor quality care. By improving the care of complex patients, and reducing their need for expensive services, we will free up funding to be reinvested in more primary and community health care for everyone. We will also have more money to put into preventative measures such as supportive housing, nutrition and recreation programs, screening, and patient self-management.

All Health Links will be accountable for achieving all of the provincial objectives. Health Links in the TC LHIN, however, are focusing immediately on three improvements in addition to local priorities:

1. Providing all complex patients with a primary care provider.
2. Providing each complex client with a coordinated care plan.
3. Ensuring complex clients see a primary care provider within seven days of being discharged from hospital.

The TC LHIN is providing a number of supports to providers. For example, we are working with hospitals to develop a standard discharge summary with meaningful and comprehensive information about the patient once they leave the hospital. This information will go directly to a patient's primary care provider and the CCAC. Some hospitals will begin to send this information electronically in 2013/14. In the future, patients will receive their own discharge summary so that they are better equipped to manage their own health.

Investing in Community Health Care

People want to remain as active and self-sufficient as possible as they age. That is why investing in community health care for older adults and other clients is a priority in the government's Action Plan for Health Care and in the TC LHIN's Integrated Health Service Plan.

Agencies that provide community support and mental health and addictions services are serving an ever-more complex and diverse group of clients. However, as a whole, community-based health providers are not yet equipped to provide the level of care that the population requires.

TC LHIN has 67 community support service organizations and 69 community mental health and addictions agencies. Even though there is a multitude of agencies, seniors and other community members, as well as primary care providers, say they are not sure what services are available in their communities. Family physicians find it complicated and time-consuming to try to register clients for community health programs, in part, because of the number of separate agencies. The fact that many of the agencies only operate Monday to Friday and during the day is problematic for people with mental illness and addictions, frail seniors and overburdened caregivers who need help on weekends and during the night.

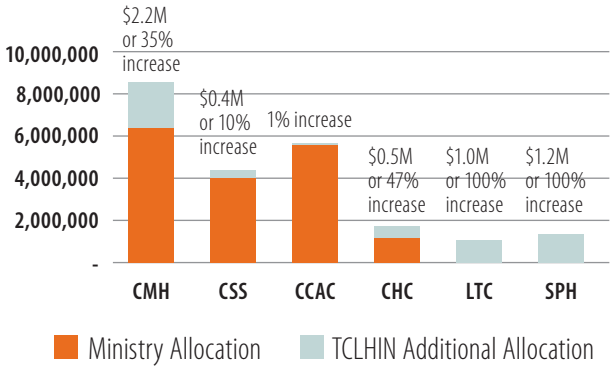
Initiatives to create single access points and phone numbers to access community health services in the TC LHIN are starting to address these challenges, however service gaps remain.

Last year the Ministry increased funding for home and community care by four percent. The TC LHIN added to this $17 million increase with another $5.4 million for a **total investment of $22.4 million in community based health services last year.**

As a result of community investment, **18 new or expanded services** for frail older adults, people with mental illness and addictions, Aboriginal women, and adults with multiple chronic conditions are enabling people to remain in their communities and enjoy a better quality of life.

The TC LHIN targeted part of this funding to assist the community health sectors to **build infrastructure.**

2012-13 Discretionary Funding for Ministry allocation ($17 M) and TC LHIN additional allocation to community sectors ($5.4 M) for a grand total of $22.4 M



Community Health Investment – Highlights

Mental Health and Addictions

Coordinated Access to Care from Hospital - *CATCH ED*

TC LHIN's Coordinated Access to Care from Hospital or CATCH-ED program was piloted last year to prevent people with mental illness and addictions from going to the ER to access health care that they could receive in the community. This program was built on an earlier program for the homeless. TC LHIN partnered with six Toronto hospitals, four community mental health agencies and four community health centres. Transitional Case Managers go into ERs and help patients connect with the community health care services they need. This program also assists clients with other needs including housing and income support.

The Concurrent Disorders Crisis Response will provide roughly 1,209 new clients with a crisis phone line, a mobile team, short-term case-management and living accommodations.

And the Community-Based Peer Outreach Worker Program led by Parkdale Activity Recreation Centre (PARC) and St. Christopher's House will provide peer support to 705 new mental health and addictions clients.

Mobile Crisis Intervention Team

TC LHIN launched a new Mobile Crisis Intervention Team (MCIT) in east Toronto. MCITs match up health nurses with police to assist people who are experiencing a mental health crisis. TC LHIN asked Rob Devitt, CEO of Toronto East General Hospital and Michael Frederico, Toronto Police Deputy Chief to lead a plan for making these teams available in all Toronto neighbourhoods.

Supportive Housing

Over the last year, 72 people living with mental illness who were living upwards of a year in hospital moved into supportive housing or long-term care.

Daniel – Regeneration House Tenant

When Daniel was diagnosed with schizophrenia, his life changed forever. He was admitted to the Centre for Addiction and Mental Health (CAMH) where he stayed as an inpatient until he was ready to move on with his recovery.

In the summer of 2012, he received keys to one of the 40 apartments at Regeneration Community's new supportive housing apartment. The program provides tenants with support with employment counselling, links to the local community health services, clinical support from CAMH, peer support, and recreational activities in the neighbourhood. This program reintegrates people back into community life, providing them with the most appropriate services. It has a positive impact on their recovery and wellbeing, and also benefits the health system by reducing the number of patients in hospital who no longer need this level of care. With the help and support he's received, Daniel is now able to plan his future.

Providing People with Personalized Care

Supporting Seniors with Behavioural Issues

In fall 2012, TC LHIN launched the Behavioural Supports for Seniors Program (BSSP). The BSSP improves the quality of life for individuals with challenging behaviours associated with dementia and other conditions, by providing a safe and supportive environment and specialized care for them and their families. The program includes a Transitional Behavioural Support Unit at Baycrest, the first-of-its-kind in Ontario, as well as new and enhanced community outreach teams and education and training for health professionals and families.

Since its launch, this strategy has supported approximately 468 older adults with behavioural challenges. Over 1,550 individuals have been trained to care for the growing number of people with behavioural symptoms related to Alzheimer's and other age-related conditions.

A Helping Hand for Caregivers

Caring for a sick loved one is often a difficult and lonely journey. Since TC LHIN partnered with the Alzheimer Society of Toronto to deliver the Caregiver Framework for Seniors in 2012, over 300 caregivers have received funds for practical supports and resources so that they can provide the best possible care to their ailing loved one.

A similar project is underway through The Hospital for Sick Children for caregivers of medically-complex children. More than 52 caregivers have received support through the project.

Quicker Recovery for Stroke Patients

With strong leadership by TC LHIN hospitals, health care providers across Toronto are working together to improve stroke care. Stroke services continued to be expanded to address identified gaps, including shifting resources from Mount Sinai and Toronto General hospitals to Toronto Western Hospital to create a critical mass of stroke expertise at that hospital site.

This year, as part of this TC LHIN initiative, hospitals launched the Walk-In Stroke Protocol for walk-in patients arriving at community hospital emergency departments. People arriving at their local hospitals suffering from a stroke will be eligible for quick transport to one of three Regional Stroke Centres – St. Michael's Hospital, Sunnybrook Hospital and University Health Network – for specialized stroke care. Once they no longer require the special services of the Regional Stroke Centre, they will be transferred back to their local hospital for care.

Helping Hip and Knee Replacement Patients Get Back on their Feet

TC LHIN is enhancing the quality of care for patients undergoing hip and knee replacement surgery by getting people home and onto recovery sooner. Outpatient services are being enhanced at a number of different organizations, including Bridgepoint Health, in order to get more patients into rehabilitation in their communities. In fact, the number of hip and knee replacement patients discharged home for ambulatory rehab increased from 64 percent in 2010/11 to 81 percent by fall 2012.

Barbara's story

When doctors told Barbara she needed a knee replacement in her right knee to manage the pain caused by osteoarthritis, she was worried about the procedure, recovery and her hospital stay.

A new program at Bridgepoint Health, called the Total Joint Replacement Program, helped Barbara transition from the hospital to the community and her home within four days – the recommended timeframe for starting outpatient rehab. She says that she was glad to get home and on to recuperation.

Evidence shows that there are better patient outcomes with this model.

Virtual Health Care

Technology is also giving people more choice in how and where they receive health care; and opening up new possibilities for self-care. Telemedicine and telehomecare have a vast potential to enhance access to services. Using virtual technology, health professionals are able to monitor their patient's symptoms, and patients are able to receive health care advice from their physician without leaving their homes.

Telehomecare has been shown to help decrease hospital readmissions and avoidable ER visits and to be an extremely effective health care investment.

Jenny's story

At 91 years old, Jenny has lived in the same Toronto apartment for 42 years. And it is important to her to continue to live there. So she decided to try TC LHIN's new Telehomecare program to help her manage her health issues, including chronic heart failure in her home using virtual technology.

A partnership between the TC LHIN, the Ontario Telemedicine Network (OTN) and the Toronto Central CCAC, the program uses OTN's technology to allow Jenny and others to receive coaching sessions remotely from the Telehomecare nurse.

At first, Jenny was skeptical about the technology, but within a few days she was convinced of its worth. During the program, Jenny became short of breath and fatigued. Through telemedicine, Jenny's telehomecare nurse tracked her vital signs and contacted Jenny's cardiologist. Not long after that, she was able to resume her daily walks.

Better Quality of Care, Better Experience

All of the positive changes that are being made in the TC LHIN can be boiled down into a singular goal: providing excellent health care for all people.

The TC LHIN has a three-part strategy to improve the quality of health care in the region:

1. Creating and improving quality common quality indicators for the system.
2. Measuring and driving improvements in the patient experience.
3. Ensuring *Excellent Care for All* by addressing health equity.

Quality Indicators

The TC LHIN brought together providers, quality improvement experts and patient advisors to select six quality improvements for which all providers will be accountable. These 'Six Big Dot Indicators' depend on different parts of the system working together and relate to improving how patients move or make the 'transition' from one provider or service to another.

The TC CCAC, community support services, mental health and addictions agencies, community health centres, hospitals and long-term care homes, are working together to achieve Six Quality Indicators.

The Toronto Central LHIN's Six Big Dot Indicators:

Theme: Appropriate Access to Care –Focusing on avoidable time in hospital and ER

1. Inpatient unscheduled readmissions within 30 days of discharge for select conditions including:
   - Stroke
   - Chronic obstructive pulmonary disease
   - Congestive heart failure
   - Cardiac diseases
   - Pneumonia
   - Diabetes
   - Gastrointestinal
   - Asthma
   - Mental health and addictions
2. Repeat unscheduled ER use within 30 days for any reason especially for lower acuity patients.

Theme: Transitions of Care – Focusing on patient experience during transitions and the length of time waiting for care

3. Percentage of hospital patients (ER or inpatient) who knew important discharge aspects. For example, danger signals to watch for after going home, medication related information, when to resume usual activities or who to call if they need help.
4. 90th percentile decision time which is the number of days from the date that the referral is sent to the final response by the receiving agency.
5. 90th Percentile waiting time from the time a patient is accepted to rehab, complex continuing care, long-term care, CCAC, community support service or community mental health agency to when they receive care.

Theme: Care for Patients with Complex and High Care Needs

6. Percent of patients with complex high care needs identified that are targeted/receiving appropriate care.

Starting in 2013/14 we will routinely review the progress on these quality improvements – for individual organizations, for entire sectors and for the system as a whole.

Improving the Client Experience

While improving health outcomes is obviously important to everyone, another part of high quality care that we are paying close attention to is people's experience in the health care system.

Knocking down some of the barriers to accessing care involves speaking to members of the community first-hand about their experiences in the health care system and considering their perspectives when we plan health services and investments. Over the last year, TC LHIN has led or participated in a number of projects that are giving patients a greater voice in health care change.

Engaging Diverse Communities; Including All Voices

The most common ways for speaking and listening to users of the health care system are designed for people who have the time to participate, speak English or French, are literate, are mobile and can access public transportation. Unfortunately, this excludes many voices. As a result, public engagement often misses the perspectives of the very people the services are intended to help. Services can be designed based on often erroneous assumptions about people's needs and preferences.

The TC LHIN is finding ways to meaningfully engage residents who face barriers to participation. Our approach includes analyzing

what populations are excluded from the public engagement process and working with their communities to develop customized methods of engaging these populations.

Health Access St. James Town

The TC LHIN, along with partners including the United Way, Toronto Community Housing and St. Michael's Hospital, created a plan to improve health access in the community. What was different about this approach was that residents had a real say in planning health services for their community and are involved throughout the process of implementing and then evaluating the changes that they themselves identified.

Animators from communities were trained on how to survey fellow community members about their health care needs. Animators represented the following communities: Afro-Caribbean; Anglo; Bengali; Filipino; Hindi; LGBTQ; Mandarin; Nepalese; Older Adults; People with Disabilities; Private market tenants; Punjabi; Spanish; Tamil; Telegu; Toronto Community Housing tenants; Urdu; and Youth. Discussions were held in people's first languages. More than 500 residents of St. James Town were interviewed over four weeks.

A series of open community meetings are taking place at every step and a website and newsletter are keeping residents informed.

"I think my role as an animator comes to me naturally. I've lived in St. James Town for more than 12 years. My experience as an animator was empowering and I gained more insight into the issues facing my community.

I was assigned two languages: English and my native Urdu. I found engaging English-speaking residents challenging. They did not want to open up because of my different ethnicity. As many people know, St. James Town is a gold mine for researchers because of its demography and diversity. But I think a lot of residents who didn't know me thought that I was just another 'do-gooder' who wanted to study them for nothing. In contrast, Urdu-speaking residents were comfortable with me because there was an element of trust between us. In the survey process, I incorporated my deep understanding of the neighbourhood and used my contacts to engage the community."

Amina Chaudhary, Coordinator of the Mobile Dental Clinic, Wave 1

Survey results from St. James Town Residents, October 2012

- People overwhelmingly turn to primary care physician for complex health issues (73.4%).
- Immigrants are more likely to see multiple providers (66.6%) and more likely to use walk-in clinics (54.9% vs 44.6%).
- Nearly 60% waiting 2-3 weeks to get a primary care appointment. Waits are longer for immigrants.
- Most people report some form of difficulty communicating with a health professional.

Health Services put in place in St. James Town, including Mental Health Access Day Programming for Seniors and a Mobile dental clinic bus, reflect what residents say is important to them.

"The dental bus is really good. The staff is so friendly and helpful and they made my 18-month old son feel comfortable. It's really helpful and convenient to have (the dental bus) here and now I don't have to worry about getting to the dentist."

Orit, St. James Town Resident

"I was so happy to be included… it has been a very long time since I have been invited anywhere… This group has provided me with the added support I need to keep me out of the hospital. There have been changes in my life, but having this group to go to in my own community will provide me with the stability I need."

Bobby, member of the seniors group in St. James Town

Mount Dennis Community Engagement

Over the last year, the TC LHIN partnered with Patient Destiny, a patient-led group, to directly engage residents of Toronto's Mount Dennis neighbhourhood. TC LHIN reached out to populations that have unique health needs and challenges including new immigrants, single-parent families and at-risk seniors from across ethnocultural groups.

Special meetings were held with different groups in the community. Invitations were translated in different languages and interpretation support was available. For example, Les Centres d'Accueil Héritage hosted a focus group with Francophone seniors at its Adult Day Program.

A cultural event hosted by the Somali Immigrant Women's Association focused on the distinct challenges experienced by Somali immigrants and generated recommendations about changes that the community thinks would make a difference.

A report on feedback from the community will be broadly distributed to providers, community

Top Issues Identified by Mount Dennis Residents:

- Lack of readily available information on health services and care options.
- Lack of effective transportation.
- Lack of services and financial resources in the community.
- The need to recognize the true cost of seeing a health service provider – time is money!
- The need for culturally-sensitive services.

members and stakeholders in spring 2013. The report will be highly relevant to the West Toronto Health Link as it begins to form and understand community needs in 2013/14.

Aboriginal Health

The TC LHIN has a number of interrelated initiatives in partnership with Aboriginal community groups aimed at improving health outcomes and experiences of both the urban Aboriginal people who live in the LHIN and individuals from First Nations, Inuit and Métis communities who come here for care.

Partnership with Ontario Federation of Indian Friendship Centres

This year, we have fostered crucial partnerships to advance culturally competent care for Aboriginal people. The Ontario Federation of Indian Friendship Centres (OFIFC), a provincial Aboriginal organization representing the collective interests of 29-member Friendship Centres located in towns and cities throughout the province, has become a TC LHIN health service provider. This year we funded OFIFC for three Aboriginal mental health and addictions projects to address barriers to appropriate mental health care, as well as a cultural competency training program specially designed for employees of TC LHIN provider organizations.

Cultural Competency Training

The OFIFC-led Aboriginal Cultural Competency Training project has trained staff and Executive Directors from 60 local mental health and addictions agencies. In 2013/14, the TC LHIN will invest in Aboriginal cultural competency training for staff and Executive Directors of community support services agencies.

New services for Aboriginal Youth Experiencing Mental Illness and Addictions

Aboriginal youth aged 16 to 24 have significantly higher rates of mental illness and addictions than the general population. To help address mental illness and addictions among Aboriginal youth, TC LHIN engaged youth to design and launch two new services geared to the specific needs of Aboriginal youth moving into adulthood.

> "Specialized programming will help (Aboriginal) youth find healing and strategies to face the challenges ahead and understand how mental health is influenced by a variety of factors including but not limited to cultural, socio-economic, physical, emotional and spiritual health and family supports,"
>
> *Jeff D'Hondt, Manager Clinical Services at Native Child and Family Services of Toronto.*

Eshkiniigjik Naanwechigegamig, translated from Ojibway means "A Place for Healing our Youth." The drop-in program provides mental health and addictions case management, referral and assessment service within the traditional Aboriginal cultural matrix of healing. This is a partnership among Native Canadian Centre of Toronto, Madison Community Services, Central Toronto Community Health Centre and Noojimawin Health Authority.

The second program called, "Serving Aboriginal Transitional-Aged Youth with Mental Health and

Addictions Issues: a Cross-Sectoral Community Model" is a new community support team comprised of two full-time community support case managers based at Native Child and Family Services. These case managers provide culturally-based traditional counseling and other supports. The initiative is a partnership among LOFT Community Services, Centre for Addiction and Mental Health and a range of organizations with extensive experience serving transitional-aged youth with mental health and addictions issues.

Better Information for Health Services Planning

The lack of culturally relevant and reliable data about Aboriginal, First Nations, Métis and Inuit peoples is a significant challenge. This past year, as part of our effort to improve information about Aboriginal health, the TC LHIN funded Well Living House, an indigenous research unit housed out of CRICH, to develop a community relevant health assessment framework.

Aboriginal Services for Women in YWCA Building

Last year we recognized a service gap for Aboriginal women living in Aboriginal units at YWCA's affordable housing complex on Elm Street. Working with the YWCA, mental health and addictions agencies, and in consultation with Aboriginal tenants, we invested in ongoing supports for Aboriginal women living in the building.

Three engagement sessions were held with Aboriginal youth aged 16 to 24 experiencing mental illness and addictions. The sessions were led by Aboriginal youth mentors and supported by Anishnawbe Health Toronto. Here is what the youths said works in the health system:

- Services based in language, tradition and culture;
- Programs that foster resiliency, self-worth and self-identity;
- Aboriginal youth/peer led initiatives – youth leading youth;
- Harm reduction approaches to services in mental health and addictions;
- Support circles, Talking Circles for families, parents and caregivers of youth experiencing mental health and addictions issues;
- Programs that offer opportunities for artistic expression;
- Programs that offer support and incentives to attend programs, e.g., transportation, food, and child care;
- More collaboration, e.g.,better access to information about where programs for youth are happening;
- Opportunities for workers to build knowledge and deal with vicarious trauma.

Ontario Off-Reserve Aboriginal Housing Trust

In an agreement between the Government of Canada and the Government of Ontario, $20 million was designated in 2007 for off-reserve housing units for Aboriginal families. Close to 100 units have been built or are under construction in the TC LHIN. The LHIN is working with Ministry of Housing and others to make sure that supports are in place when people move in. Staff at Na-Me-Res worked with Aboriginal agencies and Parkdale-area providers to ensure new tenants coming from shelters have needed supports to manage their health and remain housed.

Francophone Health

The TC LHIN is committed to enhancing the availability and "active offer" of French Language Services (FLS) across the region.

Improving Data for French Language Services Planning

The TC LHIN is working with, Reflet Salvéo, the French Language Health Services Planning Entity for Toronto Central, Mississauga Halton and Central West LHINs, to conduct a community needs assessment, and to map health services available in French in the three LHINs. At the same time, the TC LHIN has initiated a health service provider capacity survey to gain an understanding of the availability of FLS.

Capacity of Providers to Deliver FLS

Health service providers in the TC LHIN are creating FLS plans for how their organizations will continually improve the availability of services in French.

A number of hospitals are leading the way by developing collaborative FLS improvement plans to enhance the impact of the Francophones and reduce duplication.

Including the Francophone Voice in Service Planning

In addition to several advisory reports from Reflet Salvéo on services for Francophones with mental illness and addictions and HIV/AIDS, Francophones have been consulted in the TC LHIN's Integrated Health Service Plan; Health Access St. James Town and Mount Dennis Engagement projects; and involved in think tanks regarding investments in community care and TC LHIN's Primary Care Strategy.

Measuring the Patient Experience

Most problems occur for patients when they move from one service to another. Yet there has been little information about and attention to the patient's experience across their care journey. TC LHIN conducted 50 engagements with over 30 providers to learn how they measure and improve the patient experience. We found there are vast inconsistencies in how agencies collect and report this information. Patient feedback is only in English or French and focuses on a single health care experience.

The TC LHIN's Patient Experience Measurement Initiative aims to improve

measurement of patient experience by standardizing the type of information that is measured by health care organizations. We took two important actions last year.

A common email survey tool piloted at St. Joseph's Health Centre will enable patients to provide feedback in specific terms at or close to the time they are receiving care, via email.

The 32 community support agencies involved in Community Navigation and Access Program (CNAP) are working to standardize the way they measure the client experience. The first step is creating a common survey tool to evaluate seniors' satisfaction with health care.

Providing Excellent Care for *All*

Collecting Vital Health Information

For the first time in Canada, TC LHIN is now asking all hospitals to collect socio-economic data at the point of care. This builds on a successful hospital-led pilot over the last few years. Through this initiative, TC LHIN area hospitals will routinely collect information from patients about income, race, sexual orientation and other key demographic data. With the elimination of the Statistics Canada long form census, this data is more critical than ever and will be extremely useful in health system planning. This information will enable hospitals to determine whether different patients are receiving appropriate care and develop strategies to ensure all patients receive the same standard of care.

Hospitals will ask patients a key set of questions about their backgrounds :

- What language do you feel most comfortable when speaking with your healthcare provider?
- Were you born in Canada? (If no, what year did you arrive?)
- Which of the following would best describe your racial or ethnic group?
- Do you have any of the following disabilities?
- What is your gender?
- What is your sexual orientation?
- What was your total family income before taxes last year?

Note that the full questionnaire asks more detailed questions related to these 7 areas.

Language Services Toronto

Last year the TC LHIN launched Language Services Toronto, a GTA-wide service that helps non-English speaking patients communicate with doctors, nurses and other health professionals with the aid of a telephone interpreter.

- 17 hospitals and 15 community agencies now offer phone interpretation through this program.
- Available in over 170 languages.
- Sharing the cost has reduced rates at some hospitals by up to 80%, with savings reinvested in patient care.

Financial Picture – 2012/13

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.

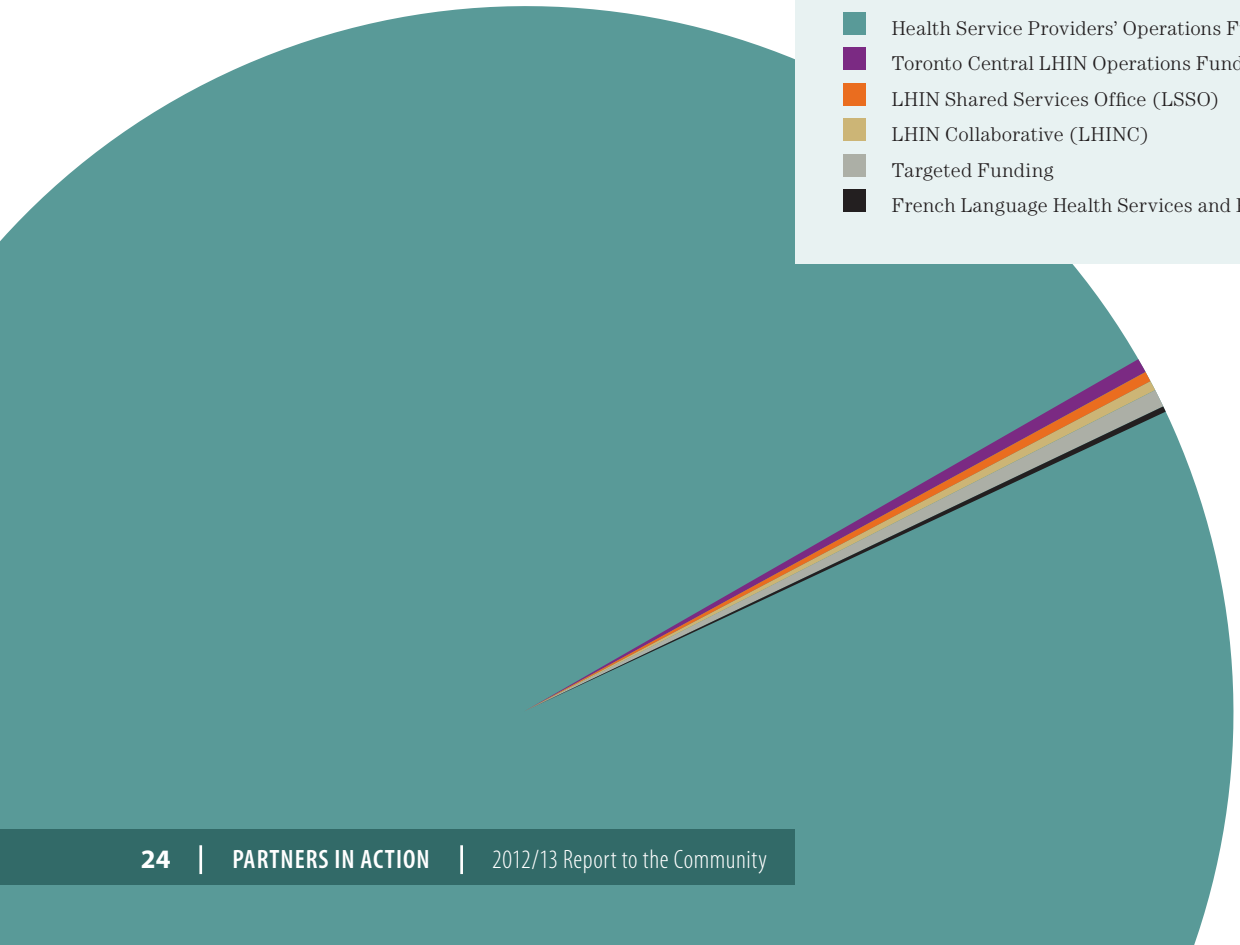
Toronto Central LHIN Operations Funding – This is funding to operate the Toronto Central LHIN organization.

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).

2012/13 Expenses

Health Service Providers' Operations Funding	$4,598,102,507
Toronto Central LHIN Operations Funding	$6,860,939
LHIN Shared Services Office (LSSO)	$6,094,232
LHIN Collaborative (LHINC)	$1,025,647
Targeted Funding	$41,886,198
French Language Health Services and Planning Entity	$527,475

Toronto Central LHIN Expenses



The Toronto Central LHIN's Health System Performance Scorecard

Overall TC LHIN was within acceptable performance range for 12 out of 15 indicators. The agreed upon acceptable performance range with MOHLTC is 10% from target for all measures.

Grouping	MLPA Indicator*	Performance
Emergency Room/ Alternate Level of Care	Percentage of ALC days	Within range
	90th Percentile ER length of stay for admitted patients	Outside range
	90th percentile ER length of stay for non-admitted complex patients	Within range
	90th percentile ER length of stay for non-admitted minor/ uncomplicated patients	Within range
Surgical Wait Times	90th percentile wait times for Cancer Surgery	Within range
	90th percentile wait times for Cardiac Bypass	Within range
	90th percentile wait times for Cataract Surgery	Outside range
	90th percentile wait times for Hip Replacement Surgery	Within range
	90th percentile wait times for Knee Replacement Surgery	Outside range
Diagnostic Wait Times	90th percentile wait times for MRI Scans	Within range
	90th percentile wait times for CT Scans	Within range
Excellent Care for All/ Quality	Readmission within 30 Days for Selected Case Mix Groups (CMGs)	Within range
Mental Health and Substance Abuse	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions	Within range
	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions	Within range
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)	Within range

Definition of Case Mix Groups: Stroke, chronic obstructive pulmonary disease and congestive heart failure, and cardiac for patients under age 40, and pneumonia, diabetes and gastrointestinal conditions for patients of all ages.

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.*

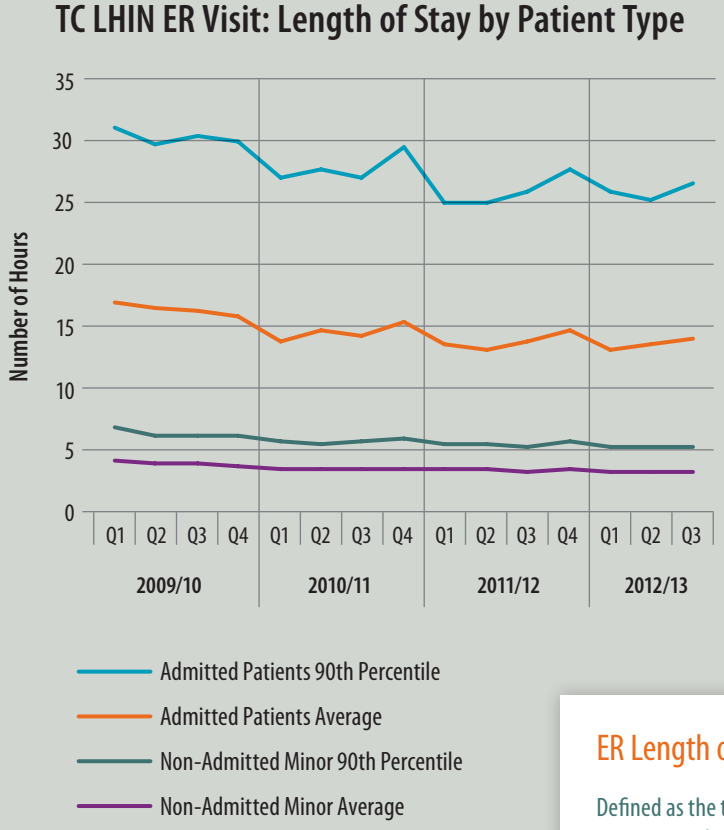
The Toronto Central LHIN's Health System Performance Scorecard *continued*

Emergency Room Visits

What's Important?

After a general downward trend over the last several years, the length of stay in the ER for admitted patients increased slightly towards the end of 2012/13. This trend appears cyclical and will likely trend down again in spring after flu season. TC LHIN acknowledges the significance of an effective ER to the system and most importantly to the patients. Hospitals are therefore committed to improving this number.

TC LHIN hospitals continue to decrease the amount of time spent in ER for non-admitted, minor patients. Currently, the majority of these types of patients are treated and discharged in less than 4.7 hours. As noted, hospitals are overcoming challenges like flu volumes and holiday closures to perform well in this area.



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 July-September 2012?

Admitted

9 were treated in less than 25.1 hours

1 waited longer than 25.1 hours

Non-Admitted Uncomplicated

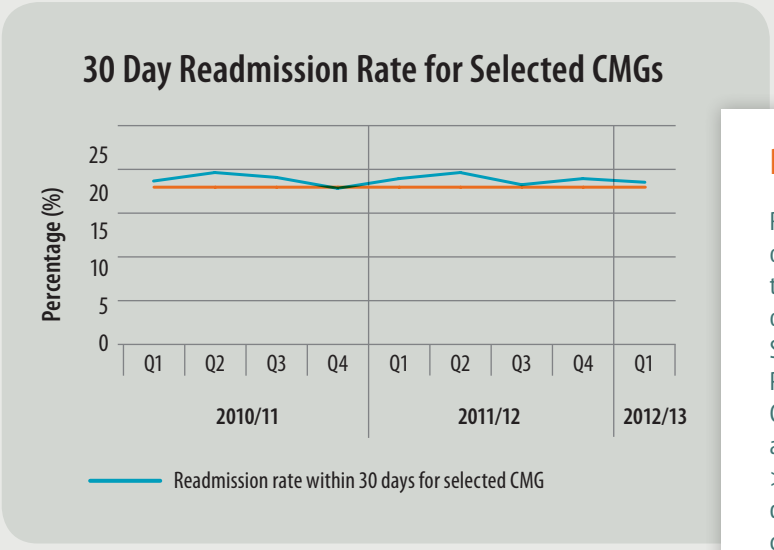
9 waited less than 4.7 hours

1 waited longer than 4.7 hours

Readmission Within 30 Days: Selected Case Mix Groups

What's Important?

TC LHIN has the second highest rate of readmissions in the province at 18.6%, which is slightly above target. While some degree of readmission is expected, the TC LHIN continues to work towards ways to improve this rate to ensure patients with a condition in one of the selected Case Mix Groups do not return to hospital unexpectedly.



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.

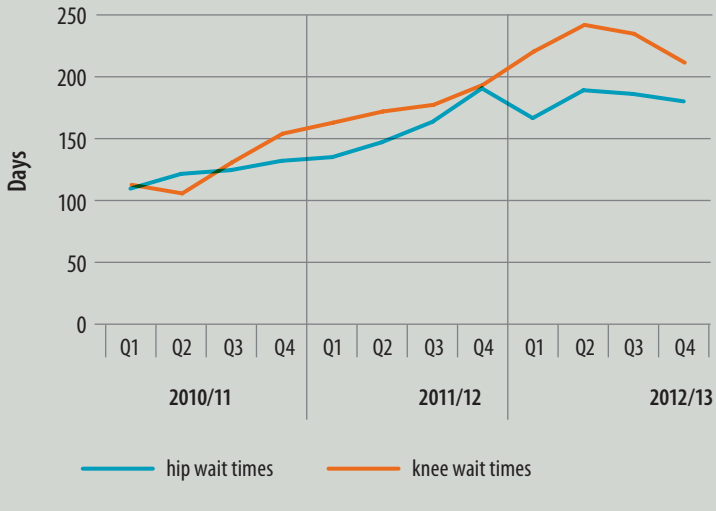
What is a repeat Re-admission?

Discharge From TC LHIN Hospital unit for 1 of the 7 conditions → Unplanned or urgent admission to hospital

Wait Times for Hip and Knee Replacement Surgeries

What's Important?

The provincial target for both hip and knee replacement surgeries is 170 days. Although the number of days patients waited for surgery peaked in Q2 2012/13, there was a downward trend for both towards the end of the period and hip replacements are back within the target range. There are factors that can increase rates, such as patient preference, however the TC LHIN continues to works towards reducing these wait times.



Wait Time

Reflects the time between a patient's and surgeon's agreed upon decision to proceed with surgery, and the time the procedure is conducted.

Looking Ahead to 2013/14

Health Links

We will work to get all nine Health Links moving forward over the next year. We expect that patients will begin to notice a difference soon. More complex clients will have their own primary care provider and we expect to see marked improvement in the number who see a primary care provider in under one week after they leave the hospital. These clients will also be supported by a care coordinator or case manager who will make sure they receive all the services they require.

Better Services for Complex and At-Risk Clients

This year, TC LHIN is leading an initiative to improve and expand key services for complex and at-risk clients. Informed by clients and caregivers, providers and the latest evidence, these improvements will include:

- Central hubs and a single phone number available 24/7 to make it easier for primary care providers to refer clients for community support and mental health and addictions services and for clients to access these services directly.
- Community services for complex and at-risk clients available during the night and weekends.
- A care coordinator responsible for coordinating services for each complex and at-risk clients.
- Easier referral process to appropriate specialist services and diagnostic imaging (e.g., MRIs and CT scans). Each hospital will have a single contact for all specialist appointments and automated client referrals and scheduling.

Public Reporting

Over the next year, the TC LHIN will launch a public report on health care performance. This online report will provide greater insight into health services in the LHIN and shine a light on areas requiring attention and improvement.

Improving Population Health

We will pursue partnerships to improve the health and wellbeing of the population as a whole. For example, the TC LHIN's Strategic Advisory Committee, which draws together representatives from health care, academic institutions, social services, the City of Toronto and provincial government will be one way to collectively address health and wellness in the city, including seniors' care and promoting children's and youth's physical and mental health.

Partners in Action

Toronto Central **LHIN**

Report to the Community 2012/13

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