# Annual Business Plan

2011-2012

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## Central LHIN 2011-2012 Annual Business Plan

### Mandate and Strategic Directions

Central LHIN is one of 14 Local Health Integration Networks (LHINs) established through the *Local Health System Integration Act, 2006*, by the Ontario government to plan, coordinate, integrate and fund health services at the local level.

The Central LHIN Integrated Health Service Plan 2010-2013 (available for download from the website at www.centrallhin.on.ca ) outlines four planning priorities – determined through extensive engagement with many stakeholders – that will be the focus of our activities and local investments over a three-year period including:

- Emergency Department and Alternate Level of Care
- Chronic Disease Management and Prevention
- Mental Health and Addictions and
- Health Equity.

The 2011-2012 Annual Business Plan outlines specific action plans and performance measures related to each of these four priorities.

### Overview of Agencies Current and Forthcoming Programs/Activities

For 2011-2012, Central LHIN's budget is approximately $1.7 billion, to be allocated across a range of health programs, delivered by 90 health service providers, including:

- Seven public and three private hospitals,
- Forty-six long-term care homes,
- Forty community support service providers,
- Twenty-two mental health and addictions service providers,
- One community care access centre, and
- Two community health centres.

(Many health service providers deliver care and services in multiple sectors.)

Central LHIN residents benefit every year from targeted investments in additional one-time funding, which enables health service providers to perform more procedures such as cardiac and cancer surgeries, hip and knee joint replacements, and MRI and CT scans.

These investments, as well as others funded through specific programs such as Aging at Home and Emergency Department Pay for Results, have reduced wait times for many of these procedures, and enhanced access to services, helping to ensure patients receive timely and responsive care in the most appropriate setting.

## Environmental Scan

Key drivers of change in the Central LHIN include high population growth (19.2% over the next 10 years compared to 12.3% in Ontario) and an aging population (an anticipated increase of 40% for those age 65 + over the next ten years). In addition, Central LHIN is geographically varied: although the LHIN is primarily urban – about 70% of the population resides in North Toronto, Vaughan, Richmond Hill and Markham – there is a significant rural region to the north which can represent a challenge to residents when accessing services.

The residents of Central LHIN are also diverse, with the highest proportion of immigrants in the province and twice the provincial average of visible minorities. Central LHIN is home to a small population of Aboriginal/First Nations people and approximately 3.2% of the population is Francophone.

Central LHIN has identified a number of issues that could affect the success in reaching the goals of our Integrated Health Service Plan. These include:

- The ability to recruit and retain appropriate health human resources – to be addressed through additional planning activities to integrate services in order to reduce gaps and improve linkages among health service providers, and explore opportunities to create additional capacity.
- The adequacy of financial resources – to be addressed through enhanced performance management and efficiency strategies.
- Varying levels of stakeholder engagement – to be addressed through a renewed approach to stakeholder and community engagement.

Central LHIN is also committed to supporting a range of key enablers through various initiatives such as those aligned with the recent *Excellent Care for All Act 2010* (including "Resident's First" long-term care quality improvement project), e-health strategies, a Wait Times Strategic Advisory Group, renewed engagement with primary care providers, improved cross-sector/cross-Ministry collaborations, the development of a strategy to build capacity in the community support services sector, and a clinical service plan to help guide planning in the years to come.

Refocused Action Plans reflect new provincial projects that were launched in 2010/11. These are most notable in the Emergency Department and Alternate Level of Care Priority and stem primarily from discussions at the September, 2010 "Stocktake" meeting. Initiatives such as the "Senior Friendly" hospital project, the "Falls Prevention" program, enhancing "Home First" and other transitional care options and services were initiated in 2010 and have been fully integrated into Central LHIN's 2011/12 Annual Business Plan.

The priorities in the Integrated Health Service Plan were chosen through a weighting and ranking method that included alignment with Ministry priorities, potential to address gaps identified in our Health Service Needs Assessment and Gap Analysis, and potential to improve sustainability. The impacts of successful implementation of our Integrated Health Service Plan are expected to include enhanced access to an integrated health care system, improved health status of residents and improved health system sustainability.

## EMERGENCY DEPARTMENT AND ALTERNATE LEVEL OF CARE

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Emergency Department and Alternate Level of Care

IHSP Priority Description:

Reducing time spent in the emergency department waiting for care is a complex issue that is both a provincial priority and a Central LHIN planning priority. Because moving people through the emergency department depends, in part, on the ability to either admit patients to acute care beds, or to discharge patients to appropriate destinations, reducing wait times cannot be solved by focusing on the emergency department alone. Central LHIN's emergency department and alternate level of care strategy recognizes that system improvements are necessary to ensure people receive prompt emergency care and the appropriate alternatives to hospital care exist in the community.

Current Status

Number of providers providing services related to this priority:

Central LHIN funds six public acute care hospitals, one specialty public hospital providing rehabilitation services, 46 long-term care homes, one community care access centre, 40 community support service agencies, 22 community mental health and addictions agencies and two community health centres. An Emergency Department/Alternate Level of Care Advisory Network composed of approximately 13 health service providers from across the continuum of care, provides advice and acts as a resource to the LHIN.

Scope of services currently provided:

Emergency and Urgent Care - There are eight emergency department sites across the six Central LHIN acute care hospitals and one urgent care centre at North York General Hospital's Branson site.

A CCAC hospital case manager is situated in each emergency department. All hospital emergency departments are funded to provide Geriatric Emergency Management nursing services.

Three emergency medical services provide ambulance and paramedic services to Central LHIN residents

Inpatient Capacity - In 2009/10, across all Central LHIN hospitals there was the following inpatient bed capacity:

Medical Beds: 720

Surgical Beds: 445

Combined Medical/Surgical Beds: 43

Intensive and Coronary Care Beds: 106

Mental Health (Adult) Beds: 158

Complex Continuing Care Beds 167

General/Special Rehabilitation Beds 185/54

Primary Care - In addition to community-based primary care physicians, the Central LHIN has two community health centres, eleven family health teams (eight existing and three newly announced), and two Nurse-Practitioner-Led Clinics. There are also a variety of outreach teams for frail seniors living at home and living

in long-term care homes.

Long-Term Care and Community Care - As of March, 2009, there were 7,259 long-term care home beds funded and in operation in our LHIN. In 2009/10, Central CCAC had the following admission breakdown to the following types of services: acute (40% of all admissions), rehabilitation (33%), maintenance (23%), long-term supportive (2%) and end of life (2%). At present, Central LHIN community support service agencies offer a wide range of services including homemaking services, adult day programming, meals on wheels, transportation and caregiver support as well as other services to support independent living.

Number and type of clients serviced annually:

Emergency - 436,637 individuals visited Central LHIN hospital emergency departments in 2009/10, a 7.9% increase in volume from the previous year. In 2009/10, approximately 10% of Central LHIN emergency department visits resulted in an inpatient admission.

Inpatient Care - In 2009/10, Central LHIN hospitals provided 586,952 patient days of care. Alternate level of care patient days accounted for 15.43% of all relevant inpatient days for Central LHIN acute hospitals and a sensitivity analysis demonstrated that the top 5% of long-stay alternate level of care patients contributed to over 4% of the overall rate.

Long-Term Care and Community Care - As of March 2009, 7,092 long-term care beds were designated for long-stay (e.g. for permanent residents), 42 beds designated for short stay purposes such as respite, 61 beds for convalescent care and 64 for interim placement. The average length of stay in a long-stay bed is 3.0 years.

The Central CCAC delivered care to a total of 78,764 clients in 2009/10. The types of services delivered included: case management (63,048 clients), nursing care (17,640 clients), personal support (22,649 clients), occupational therapy (12,096 clients), physiotherapy (7,542 clients), speech therapy (5,081 clients), social work (1,391 clients) and dietetic services (1,255 clients) and placement services (11,110 clients).

Collectively, Central LHIN-funded Community Support Service Agencies served 32,374 individuals in 2009/10.

Key issues:

Population growth pressures, especially within the senior's population, will continue to increase demand for service. In 2008, approximately 12% of Central LHIN population was over 65 years of age. Over the next 10 years, the relative population size is expected to increase to 40% within this age cohort which will make it the third highest in the province. Inadequate bed supply (especially in the areas of rehabilitation, complex continuing care, and long-term care, compared with per capita rates) will challenge health service providers to meet demand.

Greater coordination of services is required to integrate care for people with conditions that are more highly represented in alternate level of care data (e.g. stroke, dementia, etc.).

Key Successes:

Central LHIN invested $33.6 million in Aging at Home funding in 2008/09 and 2009/10 to support initiatives designed to enhance community capacity, further develop multi-sector linkages, as well as create additional capacity to address alternate level of care pressures. A further $19.3 million was invested in 2010/11. Key initiatives funded through Aging at Home, in-year reallocation and other sources have included the expansion of rehabilitation services, the addition of 64 new interim long term care beds and 39 transitional care (restoration/rehabilitation) beds, supportive housing, adult day programming and dementia services. In addition, targeted investments have been made to support an enhanced homecare programs (including Home First and Balance of Care), an 8-bed specialized behavioural support unit, a 4-bed specialized respiratory rehabilitation unit, an expansion to Nurse-Led Outreach Teams, and expansion to acquired brain injury case management, respite, day programs and assessments.

Results reported in the November, 2010 Stocktake report demonstrate progress made in reducing time spent in

the emergency department and modest improvement in alternate level of care days:

- Number of unscheduled emergency department visits per 1000 population has remained between 59 and 64 for the last five quarters, compared to the provincial average of 99.
- 90th percentile emergency department length of stay for non-admitted patients (both complex and minor/uncomplicated) exceeds the 2010/11 MLPA target.
- Pay-for-Results emergency department indicators (proportion of admitted high acuity patients admitted within 8 hours; proportion of non-admitted high acuity patients treated within 8 hours; and proportion of non-admitted low acuity patients treated within 4 hours) are all exceeding their performance targets for 2010/11. This has been achieved despite a higher than average growth in overall emergency department visits at Central LHIN hospitals compared to other regions in the province, and a disproportionate increase in the higher acuity visits.
- Percent alternate level of care days is 15.2%, a modest reduction from the baseline of 15.43%. Of note, Aging at Home investments in the Behavioural Support Unit and specialized respiratory rehabilitation unit were able to accommodate several patients whose wait times for alternate levels of care had been greater than a year. In Q2 and Q3 of 2010/11, a total of 574 patients who were "long stay ALC" (that is, waiting more than 40 days) were transferred from Central LHIN hospitals to more appropriate care environments.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal 1

Reduce demand on emergency department services

Consistency with Government Priorities:

Central LHIN goals are aligned with the goals of the provincial emergency department and alternate level of care priority.

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Subject to the allocation of resources (including Aging at Home), invest in strategies to reduce avoidable emergency department visits | 25% | 25% | 25% |
| Through Central LHIN Advisory Networks, identify and disseminate best practices for emergency department diversion<br>• Subject to the allocation of resources, support health service provider implementation of best practices | 25% | 25% | 25% |

Measures of Success

| Maintain performance in unscheduled emergency department visits per 1000 population.<br>Achieve a minimum 10% reduction (compared to baseline) in transfers to the emergency department from nursing homes through the Nurse-Led Outreach team initiatives.<br>Meet or exceed MLPA targets for repeat unplanned emergency visits within 30 days for mental health and substance abuse conditions (see Mental Health & Addictions Goal #2 and Goal #3). |
|---|
| What are the risks/barriers to successful implementation? |
| The availability of adequate financial resources, including sufficiency of health human resources, will impact our ability to provide alternative services to the emergency department.<br>Population growth (and subsequent demand) may outpace new investments in emergency department diversion.<br>Improving discharge planning and linkages to primary care will be limited by the fact that most primary care services are outside the LHIN's mandate. |

| Goal 2 |
|---|
| Increase capacity and improve emergency department performance |
| Consistency with Government Priorities: |
| Central LHIN goals are aligned with the goals of the provincial emergency department and alternate level of care priority. |

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Subject to the allocation of resources, support health service provider participation in emergency department quality improvement initiatives | 25% | 25% | 25% |
| Support the implementation of provincial priority projects including:<br>• "Senior Friendly" Hospital Initiative<br>• "Falls Prevention" Program | 50%<br>TBD | 25%<br>TBD | 25%<br>TBD |

| Measures of Success |
|---|
| Further improvements in all Pay-for-Results emergency department wait time/length of stay indicators.<br>All Central LHIN hospitals will have completed a "Senior Friendly" assessment and mitigation plan.<br>Meet or exceed the targets for falls prevention (TBD). |

| What are the risks/barriers to successful implementation? |
|---|
| The Ministry's Pay-for-Results financial reconciliation policies may interrupt emergency department quality improvement initiatives before results have been demonstrated.<br>The availability of adequate financial resources will impact our ability to effectively address this priority, including implementation of the "Senior Friendly" strategies.<br>A Project Charter has yet to be released describing the elements of the Falls Prevention Program which may delay implementation of this initiative. |

| Goal 3 |
|---|
| Reduce length of stay in alternate level of care to improve access to hospital services |
| Consistency with Government Priorities: |
| Central LHIN goals are aligned with the goals of the provincial emergency department and alternate level of care priority. |

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Implement a comprehensive alternate level of care strategy across Central LHIN hospitals and Community Care Access Centre | 75% | 25% | |
| Enhance "Home First" implementation and other transitional care options and services through Aging at Home investments | 25% | 25% | 25% |
| Participate on LHIN/provincial working groups to optimize the use of rehabilitation and complex care resources | 50% | 25% | 25% |
| Continue local cross-Ministry/cross-sectoral collaborative planning activities to enhance complex care resources and options | 50% | 25% | 25% |
| Based on pilot project results, explore assisted living alternatives, consistent with the Ministry's Assisted Living Services for High Risk Seniors 2010 policy | 50% | 25% | 25% |
| Subject to the allocation of resources, implement applicable eHealth strategies (e.g. resource matching & referral) | 25% | 25% | 25% |

| Measures of Success |
| --- |
| An “Alternate Level of Care” Charter is signed by all Central LHIN hospitals and the Community Care Access Centre.<br>An “ALC dashboard” is created to assist with decision-making.<br>Meet or exceed the target for percent ALC and the 90th percentile ALC.<br>Successfully transition four mechanically ventilated patients from intensive care to an alternate community setting.<br>Cross-Ministry/cross-sectoral collaboration results in new, sustainable, community-based residential options for people with complex care needs.<br>Implement resource matching and referral strategy elements consistent with the provincial/LHIN plan. |
| **What are the risks/barriers to successful implementation?** |
| The availability of adequate financial resources will impact our ability to effectively address this priority.<br>Capital funding policies may impede the ability of health service providers to participate in projects that require renovations (for example, alternative housing/residential options).<br>Success is dependent on successful engagement with health service providers.<br>Resource matching and referral is subject to availability of financial resources. |

## CHRONIC DISEASE MANAGEMENT AND PREVENTION

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Chronic Disease Management and Prevention (CDMP)

IHSP Priority Description

Chronic diseases such as diabetes, congestive heart failure, arthritis and stroke have significant personal, social and economic impacts. The treatment of chronic diseases and their complications places significant demand on our acute care system and community-based services – a demand that is expected to increase with the aging of the population. Central LHIN's chronic disease management and prevention strategy focuses on streamlining the delivery system and putting a comprehensive plan in place to support self-management. It aligns with the Ministry of Health and Long-Term Care's Chronic Disease Prevention and Management Framework that envisions an integrated and coordinated system that improves clinical outcomes, reduces the burden of chronic disease, and improves the sustainability of the health care system.

Current Status

Number of providers providing services:

Central LHIN funds a wide variety of programs and services that support chronic disease management and prevention across its seven hospitals, two community health centres, the Central Community Care Access Centre and numerous community providers. Although not directly funded by Central LHIN, eleven family health teams (eight existing and three recently approved), two recently announced Nurse Practitioner-Led Clinics, over 1,380 family physicians and over 1,200 specialist physicians, three public health units, and Ministry of Health Promotion-funded programs also play a vital role in chronic disease management and prevention across the continuum of care in the Central LHIN. A Central LHIN Chronic Disease Management and Prevention Advisory Network composed of approximately twelve health service providers from across the continuum of care provides advice and acts as a resource to the LHIN.

Scope of major services currently provided:

Diabetes and Chronic Kidney Disease

There two regional Chronic Kidney Disease Centres in Central LHIN, sited at York Central Hospital and Humber River Regional Hospital. Humber River Regional Hospital has 52 dialysis stations in operation across two sites and York Central Hospital has 61 dialysis stations (including 24 new stations located in the Vaughan Health Campus of Care). Stevenson Memorial Hospital also provides dialysis services as a satellite of Orillia Soldier's Memorial Hospital. There are currently14 Diabetes Education Teams in the Central LHIN. Southlake Regional Health Centre sponsors the Central LHIN's Diabetes Regional Coordinating Centre who purpose is to coordinate and enhance diabetes services across the LHIN, in support of the provincial diabetes strategy. Humber River Regional Hospital is the Central LHIN-lead for bariatric surgery, another component of the provincial diabetes strategy.

Cardiac Care

Southlake Regional Health Centre is the Ministry-designated lead for cardiac care in Central LHIN. The program provides advanced cardiac services for residents of York Region, Simcoe County, and Muskoka in the specialty areas of cardiac diagnostics and clinics, cardiac surgery, comprehensive electrophysiology (Heart Rhythm Program), interventional cardiology (PCI), medical cardiology and cardiac rehabilitation. The five other acute care hospitals in Central LHIN offer medical cardiology services, as well as a range of cardiac

diagnostics and prevention/rehabilitation programs.

Cancer Care

Southlake Regional Health Centre is the Ministry/Cancer Care Ontario-designated lead for cancer care in the Central LHIN. The program provides advanced cancer services for residents of Central LHIN in the areas of surgical and medical oncology. Full radiation services were opened at Southlake in June, 2010. The five other acute care hospitals in Central LHIN also offer a range of surgical and medical oncology, as well as diagnostics and prevention programs.

Stroke Care

York Central Hospital is the designated District Stroke Centre in Central LHIN and provides acute and rehabilitative stroke care including:

organized stroke care to patients throughout York Region,

coordinated stroke service based on best practice and evidence,

coordination with the Regional Stroke Centre and other partners, and

leadership across the spectrum of stroke care including promotion, prevention, acute care, rehabilitation and community care.

The five other acute hospitals in Central LHIN also offer acute stroke services, as well as a range of diagnostics, rehabilitative and prevention programs.

Rehabilitation

St. John's Rehabilitation Hospital is the designated specialty rehabilitation facility in Central LHIN. The hospital provides specialized inpatient, outpatient and outreach rehabilitation services for amputations, cancer, cardiovascular surgery, orthopaedic conditions, strokes and neurological conditions, traumatic injuries and complex medical conditions. It is the site of Canada's only dedicated organ transplant and burn rehabilitation programs.

A range of inpatient, outpatient and outreach rehabilitation services are also provided by Central LHIN's other hospitals, community health centres, the Central Community Care Access Centre and many community providers.

Number and type of clients serviced annually (hospital impact)

In 2008, chronic diseases in Central LHIN accounted for 25% of inpatient cases (21,282 hospital separations), 10% of emergency department visits (34,086 visits), and approximately 67% of rehabilitation admissions.

Key issues:

Although the overall prevalence of chronic diseases in Central LHIN is lower than the provincial average, higher than average population growth will place significant demands on health service providers to meet demand in the coming years (for example, the rate of diabetes is expected to grow by 21% in the next five years and 50% in the next 10 years).

Percentage of the population with Chronic Conditions (Health System Intelligence Project, MOHLTC 2007)

| | Arthritis | Hypertension | Asthma | Heart disease | Diabetes | Depression | COPD | Cancer | Stroke |
|---|---|---|---|---|---|---|---|---|---|
| Central LHIN | 14.2 | 12.4 | 6.8 | 4.3 | 4.0 | 3.1 | 3.1 | 1.5 | 0.9 |
| Ontario | 17.2 | 15.4 | 8.0 | 4.8 | 4.8 | 4.8 | 4.1 | 1.5 | 1.1 |

According to findings in the Central LHIN's *Health Service Needs Assessment and Gap Analysis* (2008), 67% of Central LHIN residents have at least one chronic condition and 42% of those over the age of 65 have two or

more chronic conditions. Variation in prevalence rates and risk factors has been observed between the LHIN's seven subplanning areas with most notable differences including:

North York West planning area with a greater relative risk and higher prevalence for diabetes

South Simcoe/Northern York Region planning area with a higher prevalence for chronic obstructive pulmonary disorder, hypertension and heart disease

Key successes:

Over the last year a number of successes were achieved in support of the chronic disease management and prevention priority, including:

A Diabetes Regional Coordinating Centre was announced at Southlake Regional Health Centre.

A Regional Director from the Ontario Renal Network was appointed for the Central LHIN.

Through the Aging at Home strategy, several projects were funded including medication management services, provision of health promotion and wellness programs to immigrant seniors, caregiver support programs for clients with complex chronic diseases, chronic disease management and prevention programs within supportive housing programs, and expanded rehabilitation services.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal 1

Support the Ministry of Health and Long-Term Care's Diabetes Strategy

Consistency with Government Priorities:

In 2008, the Ontario Government announced a provincial diabetes strategy that included increasing access to team-based care, investing in diabetes prevention, investing in a diabetes registry, expanding insulin pump therapy, enhancing chronic kidney disease services, and expanding access to bariatric surgery. The government's focus in 2010/12 is to improve access to and quality of diabetes services and to continue to build capacity by enhancing prevention and improving disease management.

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Subject to the allocation of resources, support the continued implementation of the Ontario Diabetes Strategy addressing: | | | |
| • High risk populations projects (e.g. Centre for Complex Diabetes Care) | TBD | TBD | TBD |
| • Self-management projects | 20% | 20% | 20% |
| • The CDMS Diabetes Project (Diabetes Registry) adoption and readiness (including the Baseline Diabetes Dataset Initiative) | 15% | 15% | 20% |

| Collaborate with the newly formed Diabetes Regional Coordinating Centre to support implementation of their 2011/12 goals | TBD | TBD | TBD |
|---|---|---|---|

Measures of Success

Collaborate with the designated health service provider to support implementation of the Central LHIN Centre for Complex Diabetes Care to implement required activities within the required timeframes.

Meet the self-management project targets for training and coaching/mentoring of multidisciplinary service providers, training peer leaders and master trainers, and introduction of new tools and resources to promote and support effective self-management.

In partnership with the Diabetes Regional Coordinating Centre, Primary Care Action Group and others, develop and implement a stakeholder engagement strategy targeting primary care providers to enhance awareness of the Diabetes Regional Coordinating Centre and their targets.

Complete the readiness assessment in support of the CDMS-Diabetes Project (Diabetes Registry).

Conduct an engagement session targeted at enhancing primary care participation rates in the Baseline Diabetes Dataset Initiative (BDDI)

What are the risks/barriers to successful implementation?

The timing of the selection of the Centre for Complex Diabetes Care may delay implementation of this strategy.

Lack of clarity regarding the LHIN's role (versus the Diabetes Regional Coordinating Centre's role) may limit local coordination and integration opportunities among health service providers.

The Diabetes Regional Coordinating Centre's goals for 2011/12 have yet to be released which may delay implementation of this strategy.

Stakeholder engagement may be variable and influence participation rates in the CDMS-Diabetes Project (Diabetes Registry) and Baseline Diabetes Dataset Initiative.

Goal 2

Collaborate with the Ontario Renal Network to enhance access to dialysis services

Consistency with Government Priorities:

In 2009, the Ontario Government announced the establishment of an Ontario Renal Network. The Ontario Renal Network has been given the mandate to provide coordination and integration of renal care across the province with active involvement from the renal community. Its priorities include establishing consistent standards and guidelines for renal care and implementing information systems to measure performance.

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. |
|---|---|

| | 2011-12 | 2012-13 | 2013-14 |
|---|---|---|---|
| Subject to the allocation of resources, collaborate with the Ontario Renal Network to implement emerging priorities for chronic kidney disease<br>• Improve early identification and referral through enhanced primary care engagement | TBD | TBD | TBD |

| Measures of Success |
|---|
| In partnership with the Ontario Renal Network, the Primary Care Action Group, Chronic Disease Management and Prevention Advisory Network and others, develop and implement a stakeholder engagement strategy, targeting primary care providers to enhance adoption of strategies to delay the progression of chronic kidney disease. |
| What are the risks/barriers to successful implementation? |
| The availability of adequate financial resources will impact our ability to effectively address this priority. Additionally, funding of dialysis services is comprised of base funding and in-year/one-time allocations. The ability to meet service demands depends on continued one-time funding support.<br>The timing of announcements regarding the provincial priorities for chronic kidney disease may delay implementation of this strategy.<br>Lack of clarity regarding the LHIN's role (versus the Ontario Renal Network's role) may limit local coordination and integration opportunities among health service providers. |

| Goal 3 |
|---|
| Enhance self-management supports for chronic disease |
| Consistency with Government Priorities: |
| This goal aligns with Ontario's "*Framework for Preventing and Managing Chronic Disease*". This goal also supports reducing avoidable emergency department visits and contributing to improved emergency department performance. |

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Form a CDMP Self Management Task Group within Central LHIN to identify key priorities, develop a workplan, and identify | 20% | 20% | 20% |

| | | | |
|---|---|---|---|
| and disseminate best practices | | | |
| Increase primary care engagement within Central LHIN through the development of a primary care engagement strategy for CDMP<br>• Conduct a minimum of two primary care engagement events | 100% | | |

| Measures of Success |
|---|
| Reduce 30-day readmission rates for selected Case Mix Groups (notably Chronic Obstructive Pulmonary Disease and Congestive Heart Failure).<br>Self-management Task Group workplan priorities are successfully completed.<br>Primary care engagement sessions are successfully completed. |

| What are the risks/barriers to successful implementation? |
|---|
| The availability of adequate financial resources will impact our ability to effectively address this priority.<br>Stakeholder level of engagement may be variable and influence the implementation of self management into programs and/or services. |

| Goal 4 |
|---|
| Improve primary and secondary chronic disease prevention programs and/or services |
| Consistency with Government Priorities: |
| Reduce avoidable emergency department visits and 30-day readmission rates for selected case mix groups, contributing to improved emergency department performance |

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Align activities in support of clinical practice guidelines with the expanded role for the Ontario Health Quality Council | 50% | 50% | |
| • Disseminate best practices for chronic diseases through the Secondary Disease | 50% | 20% | 20% |

| Prevention Work Group | | | |
|---|---|---|---|
| Subject to the allocation of resources, fund new and expanded project proposals | 10% | 10% | 10% |
| Pursue collaborative opportunities with Public Health and the Ministry of Health Promotion and Sport | 10% | 10% | 10% |

Measures of Success

Reduce 30-day readmission rates for selected Case Mix Groups (notably Chronic Obstructive Pulmonary Disease and Congestive Heart Failure).

Activities in support of the Ontario Health Quality Council's best practice guidelines are implemented within the required timelines. Central LHIN dissemination of guidelines to health service providers is completed.

A framework for collaboration with Public Health and the Ministry of Health Promotion and Sport is established.

What are the risks/barriers to successful implementation?

The availability of adequate financial resources will impact our ability to effectively address this priority.

Stakeholder engagement may be variable.

The LHIN has a limited role in managing and funding primary care-based chronic disease management and prevention services.

## MENTAL HEALTH AND ADDICTIONS

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Mental Health and Addictions (MHA)

IHSP Priority Description:

People with mental health and addictions conditions have difficulty accessing care due to demands that far exceed available resources. For example, data suggests more than 100,000 individuals in Central LHIN experience substance abuse, however just over 3,800 received addiction treatment. By continuing to make mental health and addictions a priority in Central LHIN, we can focus resources to coordinate care and bridge gaps in the system, reduce wait times for assessment and services, and enhance community supports. Our mental health and addiction strategy aligns with the Ministry of Health and Long-Term Care's model for mental health and addictions service delivery.

Current Status

Number of providers providing services:

Central LHIN funds 7 hospitals, 22 community mental health and addiction service agencies and 6 Assertive Community Treatment teams that provide mental health and addiction services. A Mental Health & Addictions Advisory Network composed of approximately 14 health service providers from across the continuum of care and supported by Central LHIN staff provides advice and acts as a resource to the LHIN. Central LHIN also funds a Consumer/Survivor Network that operates out of the Lance Krasman Memorial Centre for Community Mental Health.

Scope of services currently provided:

Across Central LHIN health service providers, the following mental health and addictions services are offered:

- Five Schedule 1 hospital facilities
- Approximately 158 adult inpatient beds and 18 child and adolescent inpatient beds
- Numerous community-based mental health and addiction clinics specializing in case management, abuse, dual diagnosis, peer support, court support, eating disorders, supportive housing, vocational, concurrent disorders and problem gambling
- One Level 3 detox centre

Number and type of clients services annually:

Results from the Ministry's Discharge Abstracts Database and the Management Information System confirm that in 2009/20010, 47,276 individuals were served through Central LHIN-funded community mental health and addictions services. Of these, 13,647 individuals were seen in hospital emergency departments and 2,973 were admitted to hospital.

The Central LHIN's *Health Service Needs Assessment and Gap Analysis* (2008) identified 107,258 Central LHIN residents with substance abuse; however, utilization data suggests that only 3,837 individuals (or less than 4%) received services for substance abuse. This study also identified that between 39,332 and 56,000 residents requiring mental health services were not receiving care. The greatest gaps in unmet need appear to be in the South Simcoe/Northern York Region planning area.

Key issues:

People with mental health and addiction conditions have difficulty accessing care due to demands that exceed available resources. Emergency department wait times are due, in part, to patients seeking mental health and addictions services because alternative community-based services are not available.

Central LHIN residents wait between 1 and 9 months to access to an initial assessment, and between 1.5 and 6 months for services. Additional capacity is required for many services including supportive housing and concurrent and dual diagnosis programming. There is also a need to access withdrawal management services.

Standardized methods of data collection within the mental health and addictions sector have recently been implemented in some, but not all, community agencies. As a result, data from this sector has not always yielded an accurate assessment of needs, gaps, wait times or service utilization.

The persistent stigma around mental illness and the inability to meet diverse needs contribute to barriers for those with mental illness and substance abuse to seek treatment and for health service providers providing care.

Key successes:

Through the Aging at Home strategy, North York General Hospital implemented an emergency department diversion Project focused on helping people with mental illness. Results from the first year of operation demonstrated a 73% decrease in the percentage of repeat emergency department visits (within 28 days) with patients stating they would seek alternate services than the emergency department should another mental health crisis occur. In 2010/11 this project was expanded to include Humber River Regional Hospital.

In 2009/10, Central LHIN funded an anti-stigma education project with Central LHIN hospital emergency department employees and staff from Ontario Works and the Ontario Disability Support Program. Results indicated that 92% of participants expressed a strong desire to learn more about mental health and addictions. This project was chosen as one of 16 pilot projects in the Mental Health Commission's national anti-stigma campaign and Phase 2 will be launched in early 2011.

Beginning in late 2007, a centralized access model was implemented for case management services for individuals with mental illness who require individual support services in the communities of York Region, North Toronto and Scarborough. A two-site hub model of centralized access was developed through the York Support Services and North Toronto Support Services, and funded by Central LHIN. This model provides information, assesses for eligibility, manages a combined waitlist for Case Management and ACT Team services, supports individuals on the waitlist, and provides short-term supports to those with immediate needs. At this time, both hubs are on track to exceed their targets by March 31, 2011.

In August, 2010, Central LHIN received $551,678 in additional psychiatric sessional fee funding to support indirect psychiatric services provided by psychiatrists and general practitioners in hospitals to strengthen access to community mental health and addiction service for high risk individuals.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

**Goal 1**

Implement emerging and provincial mental health and addiction priorities

Consistency with Government Priorities:

In July, 2009, the Ontario Government released a discussion paper entitled, "Every Door is the Right Door:

Towards a 10-Year Mental Health and Addictions Strategy". The goals outlined in the document include:

- Improving health and well-being for all Ontarians
- Reducing the incidence of mental illness and addictions
- Identifying mental illnesses and addictions early and intervening appropriately, and
- Providing high quality, effective, integrated, culturally competent, person-directed services and supports for Ontarians with mild to complex mental illnesses and/or addictions.

In September, 2010, a Select Committee reported to the Legislature on its recent work, including its recommendation for a new Mental Health and Addictions Ontario agency. In December, 2010, the Minister's Advisory Group on Mental Health and Addictions released a report entitled, "Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy". Together these three reports are expected to form the basis for the implementation of the 10-year plan.

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Subject to the allocation of resources, implement applicable/approved strategies from the Ministry's Mental Health and Addictions 10-year strategy | TBD | TBD | TBD |
| Continue to participate on the Ontario Behavioural Support System initiative in accordance with its workplan | 25% | 25% | 25% |

Measures of Success

Actions/activities announced as part of the implementation of the Ministry's Mental Health and Addictions strategy are implemented within the required timeframes.

Support health service provider participation on one demonstration project associated with Phase 2 of the Ontario Behavioural Support System Project.

What are the risks/barriers to successful implementation?

The timing of the release of the action plan by the Ministry of Health and Long-Term Care may delay implementation of these strategies.

The availability of adequate financial resources will impact our ability to effectively address this priority.

The sufficiency of specialized health human resources may impede the ability to implement these strategies in a timely manner.

**Goal 2**

Reduce gaps in service and improve linkages across the continuum of care

Consistency with Government Priorities:

In July, 2009, the Ontario Government released a discussion paper entitled, "Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy". In September, 2010, a Select Committee reported to the Legislature on its recent work, including its recommendation for a new Mental Health and Addictions Ontario agency. In December, 2010, the Minister's Advisory Group on Mental Health and Addictions released a report entitled, "Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy". All three reports identify the goal of reducing gaps in service and improving linkages across the continuum of care.

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Subject to the allocation of resources, maintain the services offered through the Centralized Access Program | 10% | 10% | 10% |
| Subject to the allocation of resources, build on the results of the pilot project supporting outreach to Homes for Special Care and short-term supportive housing | 25% | 25% | 25% |
| Explore opportunities to fund additional supportive housing options for those with mental health and addictions conditions | 25% | 25% | 25% |

Measures of Success

Reduce wait times and/or increase in number of clients served by the Centralized Access Program.

Reduce repeat unplanned emergency visits within 30 days for mental health conditions.

Reduce repeat unplanned emergency visits within 30 days for substances abuse conditions.

Reduce alternate level of care days for those with mental health and addictions conditions.

What are the risks/barriers to successful implementation?

The availability of adequate financial resources will impact our ability to effectively address this priority.

The sufficiency of specialized health human resources in the community may impede the ability to implement these strategies in a timely manner.

**Goal 3**

Expand community-based mental health services

Consistency with Government Priorities:

This goal aligns with the Ministry's priority to reduce emergency department wait times, and reduce repeat unplanned emergency visits within 30 days for mental health and substance abuse conditions.

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Evaluate program and service proposals that support emergency department diversion and improve the coordination of care between hospitals and community providers<br>• Subject to the allocation of resources, fund new and expanded proposals | 25% | 25% | 25% |
| Develop and implement an engagement plan with primary care providers<br>• Conduct two education/capacity building sessions with family physicians | 50% | 25% | 25% |
| Investigate the feasibility of enhancing resources for targeted populations (e.g. Alzheimer's day program, concurrent disorder/dual diagnosis/ specialized day programs) | 25% | 25% | 25% |

Measures of Success

Reduce repeat unplanned emergency visits within 30 days for mental health conditions.

Reduce repeat unplanned emergency visits within 30 days for substances abuse conditions.

Reduce alternate level of care days for those with mental health and addictions conditions.

What are the risks/barriers to successful implementation?

The availability of adequate financial resources will impact our ability to effectively address this priority.

The sufficiency of specialized health human resources in the community may impede the ability to implement these strategies in a timely manner.

Level of engagement of primary care providers may be variable.

| **Goal 4** |
|---|
| Increase awareness of diversity needs |
| Consistency with Government Priorities: |
| This goal aligns with the diversity and anti-stigma goals outlined in the Ministry of Health and Long-Term Care's 10-year Mental Health and Addictions strategy, the Select Committee's report and the Minister's Advisory Group report. |

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Subject to the allocation of resources, expand initiatives that champion anti-stigma and cultural diversity training | 25% | 25% | 25% |
| Increase engagement with those with lived experiences and family members through the Consumer-Survivor Network and other initiatives | 25% | 25% | 25% |

| Measures of Success |
|---|
| Implement Phase 2 of the Mental Health Commission of Canada's anti-stigma project.<br>Conduct two engagement sessions with those with lived experiences and family members. |
| What are the risks/barriers to successful implementation? |
| The availability of adequate financial resources will impact our ability to effectively address this priority.<br>Level of engagement of those with lived experience may be variable. |

| Goal 5 |
|---|
| Improve the data quality and analysis of data currently collected pertaining to the mental health and addictions sector |
| Consistency with Government Priorities: |
| This goal is aligned with the Ministry of Health and Long-Term Care's strategic direction of establishing a framework for sustainability of the health care system. In particular, it supports planning and decision-making based on evidence, analysis of need and value of investment. |

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Together with a group of health service providers, conduct a data improvement project | 25% | 25% | 25% |
| Subject to the allocation of resources, implement a standardized assessment/ decision-making tool to enable key information to be electronically gathered in a more secure and efficient manner (e.g. Community Mental Health – Common Assessment Project) | 10% | 10% | 10% |

Measures of Success

Improve our understanding of the causes of repeat unplanned emergency visits within 30 days for mental health and substance abuse conditions and develop an action plan

At least 50% of those health service providers interested in adopting the Community Mental Health - Common Assessment Project are successful

What are the risks/barriers to successful implementation?

The availability of adequate financial resources will impact our ability to effectively address this priority.

## HEALTH EQUITY

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Health Equity

IHSP Priority Description:

Central LHIN's health equity priority aims to reduce health disparities within targeted population groups in the South Simcoe/Northern York Region and North York West planning areas. These areas have been identified as having higher than average incidence of serious health conditions and challenges in accessing primary care.

Central LHIN is guided by the *Local Health System Integration Act* to respond to the needs, priorities and health service delivery issues of local Aboriginal peoples and Francophone communities. In June 2009, a new inclusive definition of Francophone was introduced, increasing the total number of Francophone people in the Central LHIN to about 30,000.

A Central LHIN Health Equity Advisory Network, composed of approximately 15 health service providers from across the continuum of care, provides advice and acts as a resource to the LHIN.

Current Status

Number of Providers:

In the South Simcoe/Northern York Region planning area, Central LHIN funds two hospitals (Southlake Regional Health Centre in Newmarket and Stevenson Memorial Hospital in Alliston) and approximately 25 community-based organizations. In the North York West planning area, Central LHIN funds one hospital on three sites (Humber River Regional Hospital), two community health centres (Black Creek Community Health Centre and Vaughan Community Health Centre) and approximately 10 community-based organizations.

Scope of Services Relating to Health Equity Initiatives:

In compliance with Schedule B of the Hospital Service Accountability Agreement, the hospitals in Central LHIN have developed health equity plans that outline targeted priorities for the coming year. In compliance with Schedule E of the Multi-Service Accountability Agreement, the community service providers in Central LHIN have also developed health equity plans for the coming year. The priorities of the plans include:

- Improving availability of, and access to, multi-language and interpretation services
- Improving access to transportation services for patients/clients
- Enhancing understanding of, and sensitivity to cultural needs in health service provision

Number and Type of Clients:

The population in the South Simcoe/Northern York Region planning area consists of approximately 113,257 residents and has the lowest percentage of visible minorities in the Central LHIN. The South Simcoe area is predominately rural with small cities and towns such as Alliston while the Northern York area, also rural, includes the First Nations community on Georgina Island. Just over 11% of the population are over the age of 65 (compared to 12.4% across the Central LHIN) and 12.6% are lone parent families (compared to 15.1% across the Central LHIN). The growth rate for those over age 65 in South Simcoe/Northern York Region is estimated to be 44% over the next decade, compared to the Ontario average rate of 33%.

Georgina Island is geographically isolated and only accessible by water. There are limited health services in the Alliston, Bradford, Keswick and Sutton communities. The town of New Tecumseth (including the

communities of Alliston and Tottenham) is under-serviced in the area of primary care, with 25 practicing physicians compared to the designated complement of 30. Similarly the Town of Georgina (including the communities of Keswick and Sutton) has 19 practicing physicians compared to the designated complement of 25.

The population in the North York West planning area consists of approximately 237,884 residents. This area includes the “Jane-Finch” neighbourhood which is approximately 60% immigrants. It has the highest percentage of low income families at 20.5%, and the highest percentage (27%) of lone parent families. Fifty percent of the population is visible minority. It is the second oldest population in the Central LHIN with 14.8% of the population over the age of 65, compared to 12.4% across the Central LHIN.

Key Issues :

The South Simcoe/Northern York Region planning area has more limited primary care services available to its residents. The prevalence rate for diabetes is the third highest in Central LHIN and its residents have the highest prevalence of heart disease and hypertension. Currently the Aboriginal community consists of approximately 190 on-reserve and 500 off-reserve residents (Indian and Northern Affairs Canada, 2007). There are no primary care providers on Georgina Island area and residents must travel across Lake Simcoe to Sutton, Keswick or further to access primary care physicians. The planning area has limited access to integrated public transit and is heavily reliant on personal vehicles.

The North York West planning area has several socio-economic challenges which affect the health of this population. It has the highest percentage of low income families, single-parent families and people over age 20 with less than a high school education. This area has the largest number of diabetics and the number is expected to increase. The residents exhibit very high volumes of emergency department visits in comparison to other planning areas which has been attributed to limited access to primary care, walk-in clinics and community services to treat non-urgent cases.

Key Successes:

Over the past year, a number of key successes were achieved in support of the health equity priority. These included:

- Three new family health teams were announced, one to serve the community of Don Mills, a second team at Humber River Regional Hospital, and a third team at the Woodbridge Medical Centre. In addition, two Nurse-Practitioner Led Clinics were announced, one in Sutton and one in North York West.
- A final report on the workshop entitled, “Dialogue and Collaboration: Keys to Effective Aboriginal Patient Care” was developed and key recommendations were presented to the Ministry of Health and Long-Term Care, Health Canada and key Aboriginal and non-Aboriginal stakeholders.
- A framework and first set of hospital health equity reports were produced. A framework and first set of community support service sector health equity plans were produced.
- Approval was received for a French Language Coordinator and selection of a French Language Services Planning Entity occurred (Entité de planification pour les services de santé en français #4 Centre Sud-Ouest), the latter to be shared between Central, Central East and North Simcoe Muskoka LHINs.
- A Complex Care Roundtable was held with thirteen health service providers and stakeholders (including Public Health representatives) to discuss system opportunities and challenges in providing care to young adults with complex care needs.
- A interdisciplinary Primary Care Action Group was established to enhance primary care integration and engagement in Central LHIN.
- New guidelines for community engagement, including key criteria for health service provider engagement and an evaluation framework was developed and implemented. Ongoing engagement of the Chippewas of Georgina Island First Nation community was undertaken.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

**Goal 1**

Increase investments in health care services in identified geographic planning areas to address health service inequities, in particular to improve access to diabetes care and primary care in these areas.

Consistency with Government Priorities:

Our health equity strategy is aligned with the Ministry of Health and Long-Term Care's strategic plan (reducing barriers to access care), the Aboriginal engagement strategy and the French Language Services strategy.

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Together with municipal leaders and other key stakeholders, develop strategies and proposals for increased access to primary care services in key areas of the LHIN | | | |
| • Through the Primary Care Action Group, identify opportunities to enhance collaboration between primary care and other sectors to maximize access, service availability and patient navigation of services | 25% | 25% | 25% |
| • Collaborate with the Community Partnership Coordinator from Health Force Ontario | 25% | 25% | 25% |
| Collaborate with the newly formed Diabetes Regional Coordinating Centre to improve access to diabetes care in the South Simcoe/Northern York Region and North York West planning areas | 25% | 25% | 25% |
| Pilot the use of a health equity assessment tool for use in allocating Urgent Priorities Funding in 2011/12 | 100% | TBD | TBD |

| Measures of Success |
|---|
| Develop a process to improve collaboration between Central LHIN Family Health Teams/Nurse Practitioner Led Clinics and other primary care providers.<br>Develop and implement an engagement strategy to address primary care access for unattached patients.<br>Investigate funding opportunities to fund projects to assist unattached patients to access primary care services (e.g. mobile primary care units).<br>Develop and implement an engagement strategy focusing on primary care providers to enhance awareness of the Diabetes Regional Coordinating Centre. |
| What are the risks/barriers to successful implementation? |
| Recruitment and retention of appropriate health human resources, including family physicians and primary care nurse practitioners will be critical to supporting an expansion of primary care services.<br>Over the next decade, Central LHIN's overall population growth is expected to increase by over 19%, with growth rates for seniors over 40%. This higher-than-average growth will place additional demands on existing health care providers.<br>Transportation barriers due to geography and location of services will continue to challenge access, especially in the South Simcoe/Northern York Region planning area. |

| **Goal 2** |
|---|
| Continue to implement engagement strategies to improve relationships and collaboration across sectors with a special emphasis on Aboriginal and Francophone populations, and the public in the identified geographic areas. |
| Consistency with Government Priorities: |
| Our health equity strategy is aligned with the Ministry of Health and Long-Term Care's strategic plan (renewed community engagement and partnerships), the Aboriginal engagement strategy and the French Language Services (FLS) strategy. |

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Implement the regulations outlined in the new Francophone community engagement strategy<br>• Together with the Central East and North Simcoe-Muskoka LHINs, | 30% | 30% | 30% |

| | | | |
|---|---|---|---|
| develop an agreement on roles and responsibilities with newly selected French Language Services Planning Entity<br>• Engage selected planning entities in other LHINs as part of the French Language Services community engagement | 30% | 30% | 30% |
| Collaborate with the GTA LHINs to identify and promote French language health service opportunities | 25% | 25% | 25% |
| Facilitate dialogue and networking opportunities between Central LHIN Health Service Providers and the Aboriginal community<br>• Sponsor one follow-up engagement event<br>• Appoint members of the Aboriginal community to Central LHIN planning groups | 100%<br>100% | TBD<br>TBD | TBD<br>TBD |
| Implement the regulations outlined in the new Aboriginal community engagement strategy (*expected Spring 2011*) | TBD | TBD | TBD |
| Support the implementation of community provider community engagement strategies<br>• Facilitate quarterly meetings<br>• Assist to align strategies with health equity plans<br>• Assist in the integration of hospital and community agency plans | 100%<br>30%<br>30% | TBD<br>30%<br>30% | TBD<br>30%<br>30% |
| Support the implementation of the hospital community engagement strategies<br>• Facilitate quarterly meetings<br>• Assist to align strategies with health equity plans<br>• Assist in the integration of hospital and community agency plans | 100%<br>30%<br>30% | TBD<br>30%<br>30% | TBD<br>30%<br>30% |

Measures of Success

Together with the Central East and North Simcoe-Muskoka LHINs, establish an accountability agreement with the French Language Services Planning Entity.

Inclusion of French-speaking community members in all LHIN community engagement activities.

Continued active participation in GTA-LHIN French Language Services planning activities.

Conduct at least one Aboriginal health focused engagement event.

Appoint Aboriginal members to Central LHIN Advisory Networks and other planning groups as appropriate.

Establish health equity plan expectations/goals and community engagement strategies for inclusion in respective service accountability agreements.

What are the risks/barriers to successful implementation?

The availability of adequate financial resources will impact our ability to effectively address the implementation plan for both Francophone and Aboriginal engagement.

Delay in release of the Aboriginal community engagement regulations/strategy will delay implementation of this initiative.

Health Service Provider engagement/commitment to community engagement may be variable.

**Goal 3**

Monitor the health status indicators in the identified geographic areas in collaboration with Public Health.

Consistency with Government Priorities:

Our health equity strategy is aligned with the Ministry of Health and Long-Term Care's strategy to improve the health status of all Ontarians, especially those with the poorest health status. This goal is also aligned with the Ministry's strategy to partner with other participants in the local health care system, including Public Health.

| Action Plans/ Interventions: | Please indicate % completion anticipated in each of the next three years i.e. if the goal were to be 75% complete after 3 years and implemented equally each year, enter 25% in each column. | | |
|---|---|---|---|
| | 2011-12 | 2012-13 | 2013-14 |
| Pursue collaborative opportunities with Public Health to promote and support health promotion activities<br>• Support implementation of the provincial Falls Prevention initiative | TBD | TBD | TBD |
| Together with Public Health, monitor, analyze and disseminate population health indicators. Use results to inform resource allocation decisions wherever possible. | 25% | 25% | 25% |
| Facilitate cross-sectoral/cross-Ministry forums (including municipalities) to | | | |

| | | | | | |
|---|---|---|---|---|---|
| | coordinate service planning for priority populations<br>• Sponsor one event | 100% | TBD | TBD | |

| Measures of Success |
|---|
| Regular engagement with public health units and appointment of a public health representative on Central LHIN Advisory Networks or other planning groups as appropriate.<br>Meet or exceed the target for Falls Prevention (TBD – see Emergency Department/Alternate Level of Care, Goal #2).<br>Develop and implement at least one cross-sectoral/cross-Ministry engagement event. |
| **What are the risks/barriers to successful implementation?** |
| Need to establish a collaborative framework for engagement with Public Health to facilitate successful collaboration.<br>A Project Charter has yet to be released describing the elements of the Falls Prevention Program which may delay implementation of this initiative.<br>The availability of adequate financial resources may impact our ability to effectively address this priority. |

## Template B: 2010-11 Central LHIN Consolidated Operating Budget

| LHIN Operations Sub-category | *2011-12 Budget* | *2010-11 Actual* |
|---|---|---|
| **FUNDING SOURCES** | | |
| MOH - LHIN Operations | 4,409,622 | 4,288,477 |
| MOH - ER/ALC Lead | 100,000 | 100,000 |
| MOH - E-Health | 350,000 | 294,090 |
| MOH - ED Lead | 72,000 | 54,000 |
| MOH - Critical Care Lead | 75,000 | 72,750 |
| MOH - Aboriginal | 10,000 | 127 |
| MOH - FLHS | 106,000 | 59,090 |
| DCC Amortization | 90,000 | 123,021 |
| **TOTAL Funding** | **5,212,622** | **4,991,555** |

| **EXPENSES** | | |
|---|---|---|
| **Staffing** | | |
| Salaries & Wages | 3,124,729 | 2,921,486 |
| Other Benefits | 656,193 | 616,649 |
| **TOTAL STAFFING EXPENSES** | **3,780,922** | **3,538,135** |
| Transportation and Communication | | |
| Staff Travel | 14,000 | 13,585 |
| Governance Travel | 6,000 | 5,878 |
| Communication | 45,000 | 39,561 |
| **TOTAL Transportation and Communication** | **65,000** | **59,024** |
| Services | | |
| Accommodation | 245,000 | 259,423 |
| Advertising | 8,700 | 8,743 |
| Consulting Fees | 172,000 | 180,548 |
| Equipment Rentals | 20,000 | 19,802 |
| Governance Per Diems - Chair | 40,000 | 41,725 |
| Governance Per Diems - Others | 50,000 | 47,445 |
| LSSO Shared Costs | 385,000 | 359,495 |
| LHIN Collaborative Structure | 50,000 | 50,028 |
| Other Meeting Expenses | 98,800 | 85,604 |
| Other Governance Costs | 53,000 | 47,021 |
| Printing and Translation | 22,000 | 51,271 |
| Other Services | 27,200 | 56,307 |
| Staff Development | 50,000 | 35,598 |
| **TOTAL Services** | **1,221,700** | **1,243,010** |
| Supplies and Equipment | | |
| Supplies and Equipment | 55,000 | 28,365 |
| Amortization | 90,000 | 123,021 |
| **TOTAL Supplies and Equipment** | **145,000** | **151,386** |

| **TOTAL CONSOLIDATED OPERATIONS** | **5,212,622** | **4,991,555** |
|---|---|---|

| **SURPLUS / (DEFICIT)** | **-** | **-** |
|---|---|---|

## Template C: LHIN Staffing Plan (Full-Time Equivalents)

| Position Title | 2009/10 Actual as of Mar 31/10 FTE | 2010/11 Forecast FTE | 2011/12 Forecast FTE | 2012/13 Forecast FTE | 2013/14 Forecast FTE |
|---|---|---|---|---|---|
| CEO | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Senior Director | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 |
| Controller | 0.6 | 0.6 | 0.6 | 0.6 | 0.6 |
| Director | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| Communications Manager | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Communications Coordinator | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Corporate Coordinator | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Executive Assistant | - | 1.0 | 1.0 | 1.0 | 1.0 |
| Administrative Assistant | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 |
| Business/Operations Assistant | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Office Manager | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Project Coordinator | 3.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| Senior Coordinator | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Planner | 3.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| Consultant | 3.0 | 3.0 | 3.0 | 3.0 | 3.0 |
| Senior Consultant | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Lead, Decision Support | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Senior Planner LTC | | | 0.6 | 0.6 | 0.6 |
| Epidemiologist | - | - | 1.0 | 1.0 | 1.0 |
| **Total FTEs** | **26.6** | **29.6** | **31.2** | **31.2** | **31.2** |

## 7.4. Template D Communications Plan - Central LHIN

**Objectives: What is the purpose of the Annual Business Plan?**

The Annual Business Plan is one of two guiding documents that are critical to the work of Central LHIN; the other document is the Integrated Health Service Plan (IHSP) 2010-2013. Together, these documents outline the work that Central LHIN is undertaking to plan for health care services for the residents of the Central LHIN.

The IHSP guides the activities and accountabilities of local health service providers as described in the *Local Health System Integration Act, 2006*. Specifically, it provides an overview of the current health care system, identifies areas for focused improvement and sets standards for achievement. All of this is done to advance Central LHIN's vision of *Caring Communities, Healthier People, and Health System Sustainability*.

The Annual Business Plan sets out the activities required to support progress towards reaching the goals set out in the IHSP. The four priority goals are: emergency department and alternate level of care, chronic disease management and prevention, mental health and addictions, and health equity.

**Context: Why do we do an Annual Business Plan?**

Under the *Local Health Systems Integration Act, 2006*, and the Ministry-LHIN Performance Agreement (MLPA), LHINs are required to publish their Annual Business Plan to inform stakeholders about the LHIN's strategies and initiatives for addressing IHSP priorities. Central LHIN's Annual Business Plan is the communication vehicle to inform stakeholders of the strategic and operational plans.

**Target Audiences:**

Central LHIN engages and communicates with many stakeholder audiences, each with its own level of understanding of the health care system and the role of the LHIN in planning, funding, coordinating and integrating the system.

Central LHIN's primary stakeholders include:

- Ministry of Health and Long-Term Care
- Central LHIN Board of Directors and staff
- Central LHIN-funded health service providers including:
  - seven public and three private hospitals
  - forty-six long-term care homes,
  - forty community support service providers,
  - twenty-two mental health and addictions service providers,
  - one community care access centre and
  - two community health centres.
- Central LHIN Advisory Networks and committees
- Other health service providers not funded by Central LHIN including:
  - Physicians/Family Health Teams/Nurse Practitioner-Led Clinics
  - Public health
  - Other health practitioners

- Central LHIN Members of Provincial Parliament (MPPs)
- Municipalities
- Other LHINs

- Local and regional media
- Service clubs/community groups/associations
- Members of the public including:
    - Residents who live, work and receive services within Central LHIN boundaries
    - Aboriginals and First Nations, Francophone
    - Patients/clients/consumers and their family members

**Strategic Approach: What type of announcement?**

Central LHIN will align with the provincial strategic approach for release of the Annual Business Plan as collectively determined by the LHINs and the Ministry. This may include coordinated, same-day release of documents by all LHINs (date tbd), posting of the Annual Business Plan on individual websites and the issuing of a news release.

**Tactics:**

Central LHIN will make its Annual Business Plan available to the public by posting it on the Central LHIN website once approved by the Ministry. We will also engage with our Advisory Networks throughout its development, and share the final Annual Business Plan with our key stakeholders.

The Annual Business Plan describes many key initiatives to advance the priorities of the IHSP and each of these has its own communication strategy and approach to engagement. Central LHIN has a comprehensive range of communication vehicles that it will leverage in order to highlight progress and collective successes in achieving the IHSP priorities. These include our website, newsclips, newsletters, LHINfo Minutes and blast emails.

Central LHIN will also seek to build education and communication in support of IHSP goals and action plans into community engagements activities throughout the year, to enhance health service providers' awareness and understanding of the plan.

Central LHIN