Central LHIN

Annual Business Plan

2010-2011

Table of Contents

140 Allstate Parkway, Suite 210
Markham, ON L3R 5Y8
Tel: 905 948-1872 • Fax: 905 948-8011
Toll Free: 1 866 392-5446
www.centrallhin.on.ca

Central LHIN 2010-2011 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. Our goal is to improve the health care system: to make it better for all of us who work, live and receive health services in our LHIN.

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

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

Our 2010-2011 Annual Business Plan outlines specific action plans and performance measures related to each of those four priorities. With these two documents as our guide, Central LHIN will work to achieve our vision of caring communities and healthier people, by supporting an efficient, high-quality health care system that is there for our residents when they need it, now and in the future.

Overview of Agencies Current and Forthcoming Programs/Activities

For 2009-2010, Central LHIN's budget is $1.6 billion, to allocate across a range of health programs, delivered our 98 health service providers, who deliver a wide range of programs and services across the continuum of care including:

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

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

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

These investments, as well as others through specific programs such as Aging at Home and Emergency Department Pay for Results, have also 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 (13.7% over the next 10 years compared to 10.3% in Ontario) and an aging population (we anticipate an increase of 40% more seniors 65+ over the next ten years). In addition, Central LHIN geographically varied: although our LHIN is primarily urban – about 70 % of our population reside in North Toronto, Vaughan, Richmond Hill and Markham – we have a significant rural region in 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. Our 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 stakeholder engagement strategy.

Central LHIN is also committed to supporting a range of key enablers through initiatives such as the joint eHealth strategy with Toronto Central LHIN, a Decision Support Advisory Group to support evaluation and performance measurement, renewed engagement with primary care providers, 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.

The priorities in our 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. We anticipate that the impacts of successful implementation of our Integrated Health Service Plan will include enhanced access to an integrated health care system, improved health status of our 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 has become 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 can't 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, 35 community support service agencies, 24 community mental health and addictions agencies and two community health centres. An Emergency Services Advisory Network and an Aging at Home/Alternate Level of Care Council aid in planning and coordinating services and providing recommendations to our 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 2008/09, across all Central LHIN hospitals there was the following inpatient bed capacity related to ED/ALC patient flow:

Medical Beds: 785

Surgical Beds: 364

Combined Medical/Surgical Beds: 31

Intensive and Coronary Care Beds: 102

Mental Health (Adult) Beds: 158

Complex Continuing Care Beds (121)

General/Special Rehabilitation Beds (229/6)

Primary Care - In addition to community-based primary care physicians, the Central LHIN has two community health centres and eight family health teams (six existing and two newly announced). 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 7,098 long-term care home beds funded and in operation in our LHIN. In 2008/09, Central CCAC's 78,480 clients were assessed and admitted to the following types of services: acute (42% of all admissions), rehabilitation (30%), maintenance (24%), 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 - About 418,000 individuals visited Central LHIN hospital emergency departments in 2008/09, a 2% increase in volume from the previous year. In 2008/09, approximately 10% of Central LHIN emergency department visits resulted in an inpatient admission.

Inpatient Care - In 2008/09, the total acute inpatient separations and patient days for Central LHIN hospitals were 103,000 separations and 560,407 patient days respectively. Alternate level of care patient days accounted for 13.1% of all relevant inpatient days for Central LHIN acute hospitals. When adjusting for the top 5% of long-stay alternate level of care patients (65+ days ALC), the relative impact of alternate level of care days decreased from 13.1% of acute care capacity to 8.63% of acute care capacity.

Long-Term Care and Community Care - As of March 2009, 6,995 long-term care beds were designated for long-stay (e.g. for permanent residents), 42 beds designated for short stay purposes such as respite, and 61 beds for convalescent care or interim placement. The average length of stay in a long-stay bed is 3.2 years.

The Central CCAC delivered care to a total of 78,480 clients in 2008/09. The types of services delivered included: case management (63,365 clients), nursing care (26,829 clients), personal support (20,184 clients), occupational therapy (13,509 clients), physiotherapy (8,573 clients), speech therapy (6,453 clients), social work (1,502 clients) and dietetic services (1,430 clients).

Collectively, Central LHIN-funded Community Support Service Agencies served 111,056 individuals in 2008/09.

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. Key initiatives have included the expansion of rehabilitation services, the addition of 64 new interim long term care beds, the expansion of enhanced homecare programs (e.g. Balance of Care), as well as additional service capacity for supportive housing, adult day programming and dementia services.

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.		
	2010-11	2011-12	2012-13
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 ED diversion Subject to the allocation of resources, support health service provider implementation of best practices	25%	25%	25%

Expected Impacts of Key Action Items

Investing in emergency department diversion initiatives will reduce emergency department demand and improve emergency department performance.

Dissemination of best practices will improve the overall demand on emergency departments across the Central LHIN.

What are the risks/barriers to successful implementation?

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

Sufficiency of health human resources will impede our ability to staff community resources that provide alternative services to the emergency department.

Population growth may outpace new investments in emergency department diversion.

Robust change management processes are needed to support the evolution of service models for emergency

department diversion.

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.		
	2010-11	2011-12	2012-13
Support the improvement of emergency department performance Subject to the allocation of resources, support health service provider participation in emergency department quality improvement initiatives	25%	25%	25%
Convene expert groups to facilitate knowledge transfer of best practices	25%	25%	25%
Improve discharge planning and linkages across the sectors Subject to the allocation of resources, support pre-implementation planning of the electronic Resource Matching and Referral project through the Central LHIN eHealth Office	10%	10%	10%

Expected Impacts of Key Action Items

Health service provider participation in emergency department quality improvement initiatives will facilitate improvements in patient flow and reduce emergency department wait times.

Pre-implementation planning for the electronic Resource Matching and Referral project will assist health service providers to be in a state of readiness with respect to their information and communications system infrastructure and their internal processes and procedures for effective use of the application.

What are the risks/barriers to successful implementation?
The availability of adequate financial resources will impact our ability to effectively address this priority. Financial reconciliation policies may interrupt emergency department quality improvement initiatives before results have been demonstrated. Stakeholder level of engagement may be variable and may influence uptake of best practices.

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.		
	2010-11	2011-12	2012-13
Enhance transitional care options and services through Aging at Home investments, consistent with the Ministry's transitional care program framework	25%	25%	25%
Expand access to long-term care service alternatives in the community though Aging at Home investments	25%	25%	25%
Enhance long-term care capacity for those with specialized behavioural support needs through Aging at Home investments	25%	25%	25%
Implement applicable eHealth strategies (e.g. resource matching & referral) – see Goal #2	10%	10%	10%

Expected Impacts of Key Action Items
Enhancing transitional care options will reduce the length of stay in alternate level of care beds in hospital. The reactivation/rehabilitation component of this program is intended to enhance mobilization and improve patient outcomes. Expanding access to long-term care service alternatives in the community will reduce the length of stay in

alternative level of care beds in hospital and reduce the waiting list and waiting times for long-term care bed placement. Enhancing specialized behavioural supports will reduce the length of stay in alternate level of care beds in hospital for this group of patients.
What are the risks/barriers to successful implementation?
The availability of adequate financial resources will impact our ability to effectively address this priority. Capital funding policies may impede the ability of health service providers to participate in projects that require renovations to accommodate transitional beds or a behavioural support unit.

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, 24 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 70 health service providers and supported by Central LHIN staff aids in planning and coordinating services and provides recommendations to Central 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
- 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 2007/2008, 19,791 individuals were served through Central LHIN-funded community mental health and addictions services. Of these, 10,231 individuals were seen in hospital emergency departments and 3,961 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 expand 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 has implemented an emergency department diversion Project focused on helping people with mental illness. In a pilot project, results have demonstrated a decrease in the percentage of repeat emergency department visits (within 72 hours) from 11.1% to 3.5%, with 83% of patients stating they would seek alternate services than the emergency department should another mental health crisis occur.

In the past year, 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 indicate that 92% of participants expressed a strong desire to learn more about mental health and addictions. This project has been chosen as one of 16 pilot projects in the Mental Health Commission's national anti-stigma campaign.

In 2009, the Diversity Mental Health and Addictions Work Group completed a cultural competency project. This project examined current awareness, engagement and implementation of cultural competency and approach to diversity within mental health and addiction agencies and programs. One of the recommended next steps is to work with the Central LHIN mental health and addictions organizations at the governance level to incorporate cultural competency strategies into their strategic plans. It is expected that this will create a sustainable approach to increasing cultural competency of health service providers and thus increase access to mental health and addiction services for Central LHIN residents from diverse communities.

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 have estimated they will exceed their targets by 50% to 100% by March 31, 2010.

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.

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.		
	2010-11	2011-12	2012-13
Subject to the allocation of resources, implement applicable/approved strategies from the Ministry's Mental Health and Addictions 10-year strategy	TBD	TBD	TBD
Participate on the provincial Behavioural Support System initiative in accordance with its two-year workplan	TBD	TBD	TBD

Expected Impacts of Key Action Items

Implementing approved strategies from the Ministry's 10-year strategy will contribute to reducing the burden of mental health and addictions-related illnesses and support an integrated health care system.

Participating on the provincial Behavioural Support System initiative will enhance sharing of best practices and knowledge transfer, and enhance the integration of the LHIN's Aging at Home, chronic disease management and prevention, emergency department, alternate level of care, and mental health and addictions strategies to benefit those with complex mental health, dementia or other neurological 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 may impede the ability to implement these strategies in a timely manner.

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

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" (see Goal 1).

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.		
	2010-11	2011-12	2012-13
Subject to the allocation of resources, enhance the services offered through the Centralized Access Program	10%	10%	10%
Explore opportunities to expand residential withdrawal management	25%	25%	25%

Expected Impacts of Key Action Items

Enhancing the services offered by the Centralized Access Program will increase access and improve coordination between services.

Exploring opportunities to expand residential withdrawal management will inform planning activities.

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, improve utilization

and improve 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.		
	2010-11	2011-12	2012-13
Evaluate program and service proposals that support emergency department diversion and improve the coordination of care between hospitals and community providers • Subject to the allocation of resources, fund new and expanded proposals	25%	25%	25%
Develop and implement an engagement plan with primary care providers • Conduct two education/capacity building sessions with family physicians	50%	25%	25%
Evaluate the feasibility of developing a regionalized peer support plan	25%	25%	25%
Investigate the feasibility of developing resources for targeted populations (e.g. Alzheimer's day program, concurrent disorder/dual diagnosis/ specialized day programs)	25%	25%	25%

Expected Impacts of Key Action Items

Expanding successful emergency department diversion projects will increase awareness of community supports for mental health and addictions, reduce future unscheduled initials visits to hospital emergency departments, and reduce the number of readmissions to hospital emergency departments.

Engaging with primary care providers will increase their knowledge of where to direct patients with mental health illness and/or addictions.

Conducting a feasibility study for a regionalized peer support plan will identify key success factor and barriers in implementing a program of this nature.

Investigating the feasibility of developing resources for targeted populations will enhance Central LHIN's understanding of service gaps and readiness to address funding opportunities.

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.

Long-standing differences in practice between hospitals and community providers may impede coordination of care.

Goal 4

Increase awareness of diversity needs

Consistency with Government Priorities:

This goal aligns with the diversity and anti-stigma principles outlined in the Ministry of Health and Long-Term Care's 10-year Mental Health and Addictions 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.		
	2010-11	2011-12	2012-13
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%

Expected Impacts of Key Action Items

Expanding initiatives that champion anti-stigma and cultural diversity will encourage those who need help to seek it.

Increasing engagement with those with lived experiences and family members will ensure their voices are heard in planning for mental health and addictions services.

What are the risks/barriers to successful implementation?

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

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.		
	2010-11	2011-12	2012-13
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%

Expected Impacts of Key Action Items

Improving Management Information Systems compliance among mental health and addictions providers will provide more accurate and timely data.

Implementing a standardized assessment tool will enable cross-sectoral partnering and planning, reduce repetitive information gathering, and improve service planning.

Improving the quality of data will support more informed decision making.

What are the risks/barriers to successful implementation?

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

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, eight family health teams (six existing and two recently approved), over 1,270 family physicians, three public health units, and Ministry of Health Promotion-funded program 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 provides advice and recommendations to Central 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 51 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). There are currently14 Diabetes Education Teams in the Central LHIN. 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 are expected to be operational in the early spring of 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 new diabetes team was announced to serve the Jane/Finch neighbourhood (sponsored by Black Creek Community Health Centre), outreach teams were announced for Georgina and Keswick and a team expansion was announced for Alliston (both sponsored by Southlake Regional Health Centre).
- An interdisciplinary and community approach to emergency diversion through a stroke prevention and health promotion program was launched at York Central Hospital. Through a network of stroke prevention clinics, patients were offered a range of programs and services to assist in the prevention of a more disabling stroke or cardiovascular event.
- 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.

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.		
	2010-11	2011-12	2012-13
Collaborate with the newly formed Diabetes Regional Coordinating Centre			
• Actively participate in the annual performance management cycle for diabetes	20%	20%	20%
• Provide input on annual objectives	20%	20%	20%
• Review opportunities to share resources	20%	20%	20%
Subject to the allocation of resources, conduct pre-implementation planning for the provincial Diabetes Registry pilot project through the Central LHIN eHealth	10%	10%	10%

Office			

Expected Impacts of Key Action Items

Implementation of a Diabetes Regional Coordinating Centre will organize and coordinate regional diabetes programming, ensure integrated service delivery that spans the continuum of care, and monitor regional performance against regional metrics aligned with the Ontario Diabetes Strategy.

Pre-implementation planning for the Diabetes Registry will assist health service providers to be in a state of readiness with respect to their information and communications technology infrastructure and their internal processes and procedures for effective use of the application.

What are the risks/barriers to successful implementation?

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

The timing of the Diabetes Regional Coordinating Centre identification and mobilization may delay implementation of this strategy.

Lack of clarity regarding the LHIN's role may limit local coordination and integration opportunities among health service providers.

The timing, workplan and funding of the Diabetes Registry will determine the implementation of this priority.

Limited availability of health service provider resources to commit to eHealth initiatives will impede our ability to effectively implement this strategy.

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 will be 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.		
	2010-11	2011-12	2012-13
Subject to the allocation of resources, implement emerging priorities for chronic kidney disease in support of the provincial renal strategy.	TBD	TBD	TBD
Work with the Central West LHIN, the			

MOHLTC and the Ontario Renal Network to address short-term dialysis capacity constraints.	20%	20%	20%

Expected Impacts of Key Action Items

Implementing approved priorities from the provincial renal strategy will contribute to reducing the burden of illness for patients with renal failure.

Working with our partners to address short-term dialysis capacity constraints will reduce wait times and/or travel time for dialysis services.

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 and MLAA targets depends on continued one-time funding support.

The timing of announcements regarding the provincial priorities for chronic kidney disease may delay implementation of this strategy.

Lack of clarity regarding the LHIN'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.		
	2010-11	2011-12	2012-13
Form a CDMP Self Management Group within Central LHIN			
• Identify key priorities and develop a workplan	50%	25%	25%
• Identify and disseminate best practices in self-management	25%	25%	25%
Increase primary care engagement within Central LHIN			

• Develop a primary care engagement strategy for CDMP • Conduct a minimum of two primary care engagement events	50% 100%	25% TBD	25% TBD
Subject to the allocation of resources, conduct pre-implementation planning for the Patient Portal pilot project through the Central LHIN eHealth Office	10%	10%	10%
Pursue collaborative opportunities with York University Faculty of Health researchers	10%	10%	10%

Expected Impacts of Key Action Items

Implementation of self-management strategies will reduce avoidable emergency department visits.

The identification and dissemination of best practices will improve the uptake of these strategies.

Engaging primary care providers will increase their knowledge, dissemination and support for self-management strategies.

Pre-implementation planning for the Patient Portal pilot project will assist health service providers to be in a state of readiness with respect to their information and communications system infrastructure and their internal processes and procedures for effective use of the application.

Collaborating with York University will integrate current research initiatives into health system planning.

What are the risks/barriers to successful implementation?

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

Stakeholder level of engagement may be variable and influence the implementation of self management into programs and/or services.

The timing, workplan and funding of the Patient Portal will determine the implementation of this priority.

Limited availability of health service provider resources to commit to eHealth initiatives will impede our ability to effectively implement this strategy.

A framework for collaboration with York University will need to be established to facilitate knowledge transfer.

Goal 4

Improve primary and secondary chronic disease prevention programs and/or services

Consistency with Government Priorities:

Reduce avoidable emergency department visits, 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.		
	2010-11	2011-12	2012-13
Form a Primary and Secondary Disease Prevention Work Group within Central LHIN to aid with the identification and dissemination of best practices for chronic diseases • Identify key priorities and develop a workplan • Subject to the allocation of resources, support health service provider implementation of these best practices	50% 25%	25% 25%	25% 25%
Pursue collaborative opportunities with Public Health and the Ministry of Health Promotion	10%	10%	10%
Subject to the allocation of resources, support health service provider participation in the Integrated Client Care Project	10%	10%	10%

Expected Impacts of Key Action Items

Improving primary and secondary chronic disease prevention programs and services will reduce avoidable emergency department visits.

Disseminating best practices will improve the overall quality of the management of chronic diseases and will ultimately reduce the burden of illness for patients.

Collaborating with Public Health and the Ministry of Health Promotion will ensure a more comprehensive and integrated approach to planning.

Supporting the Integrated Client Care Project will improve the quality of care and health outcomes for patients.

What are the risks/barriers to successful implementation?

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

Stakeholder level of engagement may be variable and influence the uptake of identified best practices into organizations.

A framework for collaboration with Public Health and the Ministry of Health Promotion will need to be established in order to clarify roles and responsibilities.

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

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.

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 the newly opened Vaughan Community Health Centre) and approximately 10community-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. The priorities include:

- Improving access and accessibility to services for mental health patients
- Improving access to diabetes education programs for seniors
- Developing specialized geriatric outreach teams for seniors
- Enhancing way-finding, signage and interpretation services

In compliance with Schedule E of the Multi-Service Accountability Agreement, the community service providers in Central LHIN will be developing health equity plans in 2010.

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 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 Alliston, Bradford, Keswick and Sutton. The town of Alliston is significantly under-serviced in the area of primary care, with only 13 practicing physicians compared to the planning target of 27. Similarly the municipality of Georgina (that includes the towns of Keswick and Sutton) has only 25 practicing physicians compared to the planning target of 33.

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 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. The town of Alliston is designated "under serviced" by the Ministry of Health and Long-Term Care for primary care. 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 is not serviced by integrated public transit and is heavily reliant on cars.

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 age 20 and over with less than a high school education. This area has the largest number of diabetics and this 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:

- A workshop was held with representatives from the Aboriginal community and all hospitals in the Central LHIN entitled, "Dialogue and Collaboration: Keys to Effective Aboriginal Patient Care",
- The Vaughan Community Health Centre was opened in June, 2009,
- A new diabetes team was announced to serve the Jane/Finch neighbourhood (sponsored by Black Creek Community Health Centre), outreach teams were announced for Georgina and Keswick and a team expansion was announced for Alliston (both sponsored by Southlake Regional Health Centre),
- A Community of Practice project was undertaken by Black Creek Community Health Centre to increase awareness of the available health services and develop a directory of services for health service providers and community members,
- A framework and first set of hospital health equity reports were produced,
- A framework for community sector health equity plans was initiated, and
- Two family health teams were announced, one to serve the community of Jane/Finch and a second team at Markham Stouffville Hospital at the Centre for Family Medicine and Intercultural Health, a Family Medicine Teaching Unit.

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.		
	2010-11	2011-12	2012-13
Together with municipal leaders and other key stakeholders, develop a funding proposal for expanded primary care in the Georgina area • 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 2010/11	100%	TBD	TBD

Expected Impacts of Key Action Items

A successful funding proposal for expanded primary care in Georgina will increase the number of people who will have access to primary care.

Implementation of a Diabetes Regional Coordinating Centre will organize and coordinate regional diabetes programming, ensure integrated service delivery that spans the continuum of care, and monitor regional performance against regional metrics aligned with the Ontario Diabetes Strategy.

The use of a health equity assessment tool will ensure that limited resources are applied to areas of greatest need.

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 support an expansion of primary care services.

Over the next ten years, Central LHIN's overall population growth is expected to increase by 14% and seniors 65+ are expected to grow by 57%. This higher-than-average growth will place additional demands on existing health care providers.

Transportation barriers due to geography and location of services will continue to challenge access, especially in the South Simcoe/Northern York Region planning area.

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

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.		
	2010-11	2011-12	2012-13
Implement the regulations outlined in the new Francophone community engagement strategy			
• Provide advice to the Minister on the selection of FLS planning entities	100%	TBD	TBD
• Develop agreement on roles and responsibilities with selected planning entities	30%	30%	30%
• Engage selected planning entities with FLS 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			
• Sponsor one follow-up engagement event	100%	TBD	TBD
• Appoint members of the Aboriginal community to Central LHIN planning groups	100%	TBD	TBD
Implement the regulations outlined in the new Aboriginal community engagement strategy (expected Jan 2010)	TBD	TBD	TBD
Support the implementation of community provider community engagement strategies			
• Facilitate quarterly meetings	100%	TBD	TBD
• Assist to align strategies with community provider health equity plans	30%	30%	30%
• Assist in the integration of hospital and community agency plans	30%	30%	30%
Support the implementation of the hospital community engagement strategies			
• Facilitate quarterly meetings	100%	TBD	TBD
• Assist to align strategies with hospital health equity plans	30%	30%	30%
• Assist in the integration of hospital and community agency plans	30%	30%	30%

Expected Impacts of Key Action Items

Implementing the new French Language Service regulations will ensure the provision of health care service in French in accordance with the *Act.*

Collaborating with the GTA LHINs will enhance information sharing and engagement opportunities with the Francophone community.

Facilitating dialogue and networking opportunities between Central LHIN Health Service Providers and the Aboriginal community will enhance relationships, improve cultural awareness and trust.

Implementing the new regulations for Aboriginal engagement will enhance communication and information sharing.

Supporting the implementation of community provider and hospital community engagement and health equity strategies will promote greater understanding of these issues and ultimately enhance access to health services by those in disadvantaged groups.

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.

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 groups 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.		
	2010-11	2011-12	2012-13
Pursue collaborative opportunities with Public Health to promote and support health promotion activities (e.g. influenza immunization)	25%	25%	25%
Together with Public Health, monitor, analyze and disseminate population health indicators. Use results to inform resource allocation decisions wherever possible. • Monitor results from the POWER study, ICES, the Population Health Improvement Research Network, and others	25%	25%	25%
Facilitate cross-sectoral forums to coordinate project planning for priority populations • Sponsor one event	100%	TBD	TBD

Expected Impacts of Key Action Items
Increasing immunization rates among the population will reduce the incidence of influenza, leading to decreased demand for hospital services (including decreased volumes and wait times in the emergency department, fewer admissions, etc.).

Identification of variations in health indicators among subpopulations will inform planning and resource allocation decisions. Collaborative cross-sectoral planning will ensure a more comprehensive and integrated approach to planning.
What are the risks/barriers to successful implementation?
Need to establish a framework for collaboration with Public Health to facilitate successful collaboration. The availability of adequate financial resources will impact our ability to effectively address this priority.

Template B: LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2009/10 Actuals	2009/10 Allocation	2010/11 Planned Expenses	2011/12 Planned Expenses	2012/13 Planned Expenses
Salaries and Wages	3,236,773	3,236,773	3,266,571	3,331,902	3,398,540
Employee Benefits					
HOOPP	302,595	302,595	304,009	310,089	316,291
Other Benefits	325,000	325,000	354,018	361,098	368,320
Total Employee Benefits	***627,595***	***627,595***	***658,027***	***671,187***	***684,611***
Transportation and Communication					
Staff Travel	17,500	17,500	10,500	10,710	10,924
Governance Travel	14,000	14,000	14,000	14,280	14,566
Communications	49,500	49,500	47,000	47,940	48,899
Other T&C	72,500	72,500	65,000	66,300	67,626
Total Transportation and Communication	***153,500***	***153,500***	***136,500***	***139,230***	***142,015***
Services					
Accomodation	261,288	261,288	261,288	266,288	271,614
Advertising					
Banking					
Community Engagement - Aboriginal Specific	30,000	30,000	10,000	10,200	10,404
Consulting Fees	571,500	571,500	111,900	114,138	116,421
Equipment Rentals	10,000	10,000	11,000	11,220	11,444
Governance Per Diems	140,000	140,000	140,000	142,800	145,656
LSSO Shared Costs	330,000	330,000	359,500	366,690	374,024
Other Meeting Expenses	42,500	42,500	45,000	45,900	46,818
Other Gevernance Costs	54,054	54,054	51,000	52,020	53,060
Printing & Translation	55,016	55,016	10,000	10,200	10,404
Staff Development	53,500	53,500	56,000	57,120	58,262
Total Services	***1,547,858***	***1,547,858***	***1,055,688***	***1,076,576***	***1,098,107***
Supplies and Equipment					
IT Equipment	11,250	11,250	4,136	4,219	4,303
Office Supplies & Purchased Equipment	112,446	112,446	38,000	38,986	39,766
Total Supplies and Equipment	***123,696***	***123,696***	***42,136***	***43,205***	***44,069***
LHIN Operations: Total Planned Expense	5,689,422	5,689,422	5,158,922	5,262,100	5,367,342
Annual Funding Target			5,158,922	5,262,100	5,367,342
Variance			-	-	-

Note:

1. 2009/10 Allocation is based on 2009/10 Q3 Report to MOH and amortization expense is excluded as it's a non cash item.

TEMPLATE C: LHIN Staffing Plan (Full-Time Equivalents)

Position Title	2008/09 Actuals as of Mar 31 FTE's	2009/10 Forecast FTE's	2010/11 Forecast FTE's	2011/12 Forecast FTE's	2012/13 Forecast FTE's
Administative Assistant, PICE	1	2	2	2	2
Administrative Assistant PCA	1				
Analyst, eHealth	1	1	1	1	1
Business/Operations Support Assistant	1	1	1	1	1
CEO	1	1	1	1	1
CEO Assistant		1	1	1	1
Communication Assistant					
Communications Manager	1	1	1	1	1
Consultant Performance Management	1	1	1	1	1
Consultant, Funding & Performance	1				
Consultant, Integration	1				
Consultant, Technology	1				
Controller	1	1	1	1	1
Director System Planning & Dev	1	1	1	1	1
Director, Clinical Services		1	1	1	1
Director, Performance			1	1	1
Director, Performance & Funding - Hospital Sector		1	1	1	1
Director, Strategic Alignment		1	1	1	1
Executive Assistant to the CEO	1	1	1	1	1
Interim Project Coordinator		1	1	1	1
Lead, Decision Support	1	1	1	1	1
Office Manager	1	1	1	1	1
Planner	1	1	1	1	1
Project Coordinator	3	2	2	2	2
Project Coordinator, Funding and Allocation	2	2	1	1	1
Senior Analyst, eHealth	1	1	1	1	1
Senior Consultant Decision Support	1				
Senior Consultant, eHealth	1	1	1	1	1
Senior Consultant, Performance and Funding		1	1	1	1
Senior Consultant, Planning & Integration	1				
Senior Coordinator to the CEO	1	1	1	1	1
Senior Coordinator, PCA	1	1	1	1	1
Senior Director, Performance, Contract & Allocation	1	1	1	1	1
Senior Director, Planinng, Integration & Community Engagement	1	1	1	1	1
Senior Planner		2	2	2	2
Senior Planner ER/ALC		1	1	1	1
Senior Planner, Alternate Level of Care		1	1	1	1
Senior Planner, CDMP	1				
Senior Planner, Integration		1	1	1	1
Senior Planner, Mental Health & CDMP		1	1	1	1
Team Lead, Performanc & Contract Mgmt	1				
Total FTE's	31	35	35	35	35

Central LHIN Annual Business Plan 2010-2011

Communication Plan

Central LHIN has developed its Integrated Health Service Plan (IHSP) 2010-2013 around four key priorities. These priorities will be operationalized through the Annual Business Plan, which builds upon previous years' successes. The ABP provides detailed goals, and actions plans to implement each of the IHSP priorities and how these will be measured.

A key factor in achieving our goals and objectives will be our ability to effectively partner and communicate with our health service providers (HSPs) to align our activities and meet our performance targets.

The public rollout of the plan will be approached in two stages with an initial distribution of the IHSP to all target audiences, supported by materials that contain key messages and next steps. Stage two will focus on education and communication around the ABP goals, and action plans to enhance our health service providers' awareness and understanding of the plan.

Central LHIN will employ a number of its existing communication vehicles that can be leveraged by LHIN Board Members and staff to communicate the plan to our key audiences:

Community Engagement:	Events to promote the IHSP
Brochures and Flyers:	Support material for meetings and events, mailings
Email/Mailings:	To key audiences, health service providers, public, partners
Media:	Media release, fact sheet, backgrounder
Meetings:	With advisory networks and committees to review IHSP
Newsletter:	Promoting IHSP and LHIN key messages
Website:	Media release, background information and key messages

As it was during the development of our IHSP 2010-2013, Community Engagement will remain integral to our rollout. Central LHIN will explore hosting engagement sessions across its planning areas to discuss ideas for how health service providers can work together, and to address any outstanding questions with regard to the plan.