Central LHIN

Annual Business Plan

2012-2013

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Central LHIN 2012-2013 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 2012-2013 Annual Business Plan outlines specific action plans and performance measures related to each of these four priorities.

Overview of Agency's Current and Forthcoming Programs/Activities

For 2012-2013, 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,
- Thirty-three community support service providers,
- Twenty 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 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, enhanced engagement with primary care providers, improved cross-sector/cross-Ministry collaborations, the development of a strategy to continue to build capacity in the community support services sector.

Key accomplishments over the last year have laid a solid foundation to support the priorities outlined in the 2012/13 Annual Business Plan. These include:

- Demonstrated progress towards meeting Meeting-LHIN Performance Agreement indicators such as wait times for surgical and diagnostic procedures, emergency department wait times for non-admitted patients, and repeat unscheduled emergency department visits for those with mental health and substance abuse conditions
- Development of a alternate level of care strategy that identifies and support prevention and diversion initiatives, avoidable hospitalizations, in-hospital ALC prevention strategies, and key initiatives to support system capacity and flow (including creation of addition post-acute care capacity such as transitional care and an expanded "Home First" program)
- Development of a Quality Action Plan that focuses on strengthening health service provider relationships and capacity to support a culture of quality improvement through multidisciplinary quality collaboratives, improving patient safety, improving access to the right care in the community, and improving system performance
- Development of a Community Engagement Plan that focuses on advancing health system quality, supporting primary care engagement, enhancing cross Ministry/LHIN engagement, collaborating with Aboriginal and Francophone populations, and leading community engagement best practices
- Establishment of a Newcomer/Settlement Planning Group, aligned with our Health Equity Priority, that seeks to develop strategies to address the current challenges faced by newcomers in accessing and navigating the health system

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 Annual Business Plan, in support of the 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, 33 community support service agencies, 20 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 organizations provide ambulance and paramedic services to Central LHIN residents

Primary Care - In addition to community-based primary care physicians, the Central LHIN has two community health centres, eleven family health teams, two Nurse-Practitioner-Led Clinics and numerous group and solo family practice providers. 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, 2011, there were 7,259 long-term care home beds funded and in operation in our LHIN. 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 - In 2010/11, 453,907 individuals visited Central LHIN hospital emergency departments, a 4.0% (17,000 visits) increase in volume from the previous year (provincial increase was 2.7%). In 2010/11, approximately 10.5% of Central LHIN emergency department visits resulted in an inpatient admission (source: ERNI).

Inpatient Care - In 2010/11, Central LHIN hospitals provided 552,778 patient days of care. Alternate level of care patient days accounted for 15.9% of all relevant inpatient days for Central LHIN acute hospitals and a sensitivity analysis demonstrated that the top 4% of long-stay alternate level of care patients contributed to over 4% of the overall rate (source: intellihealth, DAD).

Long-Term Care and Community Care - As of March 2011, 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.

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:

Results reported in the November, 2011 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 60 and 64 for the last five quarters, compared to the provincial average of 100.
- 90th percentile emergency department length of stay for non-admitted patients (both complex and minor/uncomplicated) exceeds the 2011/12 MLPA targets.
- Percentage alternate level of care days was 14.5% (Q1), a reduction from the baseline of 16.1%.
- Nurse-led outreach teams have demonstrated an ability to divert 80% of imminent transfers to the Emergency Department
- An Emergency Department Quality Collaborative was held to share successful strategies to improve patient flow. A second collaborative was held to share best practices around infection prevention and control in the emergency department, and their impact on patient flow.
- Resource matching and referral was implemented beginning in September, 2011 and included both inpatient and emergency department electronic referrals.

TEMPLATE A: PART 2: GOALS and ACTION PLANS
Goal 1
Reduce demand on emergency department services
Consistency with Government Priorities:
Central LHIN goals and actions are consistent with the Ministry of Health and Long-Term Care's goals of reducing demand on emergency departments, reducing wait times for emergency services, and reducing the impact of patients waiting for alternate levels 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.		
	2012-13	2013-14	2014-15
Working with Central LHIN Primary Care Lead and Health Care Connect, increase access to primary care	25%	25%	25%
Explore enhancements to community-based crisis support for mental health and addictions	25%	25%	25%
Implement a coordinated regional system to support Long Term Care home resident needs, building on Nurse Lead Outreach Teams, Behavioural Supports Ontario and new CCAC initiatives	25%	25%	25%
Expand telemedicine initiatives	10%	25%	25%
Explore implementation of all electronic medical record	50%	50%	TBD
Collaborate with the French Language Services Entity to engage the French-speaking community	50%	25%	25%

How we will measure success

Maintain the number of unscheduled emergency department visits per 1000 population (within 5%)

Maintain nurse-led outreach team diversion rates

Increase Health Care Connect matching by 5%

Number of clinical telemedicine events will increase

What are the risks/barriers to successful implementation?

Multiple change initiatives underway stretch resources of health service providers

Impact of activities may not show quick results

Key enablers

Continued successful engagement across a variety of health service provider organizations

Goal 2

Increase capacity and improve emergency department performance

Consistency with Government Priorities:

Central LHIN goals and actions are consistent with the Ministry of Health and Long-Term Care's goals of reducing demand on emergency departments, reducing wait times for emergency services, and reducing the impact of patients waiting for alternate levels 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.		
	2012-13	2013-14	2014-15
Support ongoing hospital emergency department process redesign activities to meet wait time targets	25%	25%	25%
Continue Emergency Department Quality Collaborative engagement activities with hospitals with a focus on wait times for admitted patients	50%	25%	25%
Further evaluate the impact of infection prevention and control standards on emergency department flow	50%	25%	25%
Conduct a focused evaluation of short-stay units	50%	25%	25%
Evaluate the orthopaedic transfers pilot project and implement recommendations	50%	25%	25%
Explore use of InterRAI Emergency Department screening tools for more appropriate service referrals for seniors	25%	25%	25%
Explore eReferral systems across all emergency departments to improve patient flow	25%	25%	25%

How we will measure success

Proportion of admitted patients meeting 8 hour target will be maintained

90^{th} percentile emergency department wait time for admitted patients will achieve MLPA target (within 10%)

90^{th} percentile emergency department wait time for non-admitted patients (high and low acuity) will be maintained

What are the risks/barriers to successful implementation?
Turnover in emergency department leadership Lack of appropriate hospital physical infrastructure to address infection prevention and control requirements
Key enablers
Continued effective engagement with health service providers

Goal 3
Reduce length of stay in alternative level of care to improve access to hospital services.
Consistency with Government Priorities:
Central LHIN goals and actions are consistent with the Ministry of Health and Long-Term Care's goals of reducing demand on emergency departments, reducing wait times for emergency services, and reducing the impact of patients waiting for alternate levels 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.		
	2012-13	2013-14	2014-15
Implement mechanisms to identify at-risk seniors in acute care	50%	25%	25%
Conduct a focused ALC/Rehab study and implement recommendations to improve flow	50%	25%	25%
Conduct a current state assessment of hospital discharge planning processes and implement improvement strategies	50%	25%	25%
Continue to participate on LHIN/provincial working groups to optimize use of rehabilitation and complex care resources	50%	25%	25%
Implement strategies to meet new orthopaedic and stroke acute length of stay and rehabilitation targets	50%	25%	25%
Implement next phase of Resource Matching and Referral	33%	33%	33%

In alignment with the Senior Friendly Hospital Strategy, identify opportunities to reduce functional decline for seniors while in acute care	25%	25%	25%
Explore further enhancing the role of CCAC to facilitate the transition of seniors across the continuum of care	25%	25%	25%
Enhance capacity in long-term care homes	50%	25%	25%
Implement recommendations from regional palliative care planning studies	50%	25%	25%
Explore opportunities to expand transitional care/restoration/rehabilitation resources in hospital	50%	25%	25%

How we will measure success

Achieve alternate level of care MLPA target

Maintain percent conversion to alternate level of care within two days

Continue to reduce 90th percentile alternate level of care

What are the risks/barriers to successful implementation?

Health service provider involvement in multiple and complex change initiatives

Less than 1% vacancy in long-term care homes

Sustainability of Home First program at its current size

Multiple provincial, regional and local rehabilitation initiatives underway

Key enablers

Identification of local champions to lead various initiatives

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 collaboration and partnerships with key provincial lead agencies. 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, two Nurse Practitioner-Led Clinics, over 1,380 family physicians and over 1,200 specialist physicians, and three public health units 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, led by York Central Hospital and Humber River Regional Hospital. 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 whose 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. A Regional Renal Steering Committee, reporting to the Ontario Renal Network, leads the planning of renal services in Central LHIN.

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. A Cardiac System Planning Team, chaired by Southlake,

leads the planning of cardiac services in Central LHIN.

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 medical, surgical and radiation oncology. 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. A Regional Cancer Program Steering Committee, reporting to Cancer Care Ontario, leads the planning of cancer services in Central LHIN

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.

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:

- Successful collaboration with the Diabetes Regional Coordinating Centre leading to the development of a common diabetes education program referral form and a plan for centralized referral and intake
- Successful collaboration with the Regional Renal Steering Committee leading to the development of a

regional work plan and capacity planning assessment
- MLPA readmissions for selected CMGs below target
- LHIN-wide training for self-management programs targeting both patients and health service providers. In addition, stroke prevention clinics are providing both secondary prevention and self-management training.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal 1

Support the Ministry of Health and Long-Term Care's Provincial Strategies

Consistency with Government Priorities:

Central LHIN goals and actions are consistent with the Ministry of Health and Long-Term Care's goals of improving access to services, building system capacity, enhancing prevention strategies and improving disease management, and improving the overall quality of health care services.

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.		
	2012-13	2013-14	2014-15
Support the continued implementation of the Ontario Diabetes Strategy • Explore electronic matching/referral processes from hospital to community diabetes programs • Develop a collaborative strategy with the Diabetes Regional Coordinating Centre to increase the percentage of patients receiving diabetes tests within guidelines	25% 25%	25% 25%	25% 25%
Support the continued implementation of the Ontario Renal Strategy: • Explore enhancing a regional renal program structure in Central LHIN • Expand specialized long-term care dialysis capacity	25% 50%	25% 25%	25% 25%

Monitor the emerging needs of the following provincial strategies: • Cancer Care Ontario • Cardiac Care Network • Ontario Stroke Network	 25% 25% 25%	 25% 25% 25%	 25% 25% 25%
Support implementation of the provincial Avoidable Hospitalization quality strategy by supporting quality improvement activities that reduce the readmission rates of selected case mix groups	25%	25%	25%
Support the implementation of the Ontario Integrated Vascular Health Strategy	TBD	25%	25%
Expand telemedicine initiatives	10%	25%	25%

How we will measure success
Number of diabetics receiving all three tests within target guidelines will increase Number of referrals to Diabetes Education Programs will increase Number of clinical telemedicine events will increase Achieve MLPA target for readmissions within 30 days for selected case mix groups Approval of long-term care specialized resources for people requiring in-centre haemodialysis
What are the risks/barriers to successful implementation?
Improved diabetes management is outside the LHIN mandate as it rests primarily with primary care providers Time required to obtain Ministry approvals of specialized long-term care resources Understanding the multiple root causes of readmissions for the case mix groups
Key enablers
Successful implementation of primary care lead position at the LHIN Continued effective collaboration with provincial CDMP program leaders Comprehensive and effective engagement strategies with health service providers

Goal 2

Enhance self-management supports and secondary prevention for chronic disease

Consistency with Government Priorities:

Central LHIN's goal and actions align with Ontario's "Framework for Preventing and Managing Chronic Disease".

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.		
	2012-13	2013-14	2014-15
Collaborate with the Ontario Diabetes Strategy Self-Management Initiative to identify priorities for people at risk of developing diabetes	25%	25%	25%
Explore opportunities to enhance collaboration between primary care practitioners and others to increase access and service availability of chronic disease/mental health self-management services	25%	25%	25%
Explore opportunities to expand regional, integrated secondary prevention initiatives	25%	25%	25%

How we will measure success

Expand availability of self-management programs

What are the risks/barriers to successful implementation?

Successful engagement with primary care and uptake of initiatives

Accountability for primary care services is limited to community health centres

Key enablers

Continued effective collaboration with provincial diabetes and self-management leads, and Public Health

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 6 hospitals, 20 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 163 adult inpatient beds and 19 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 2009/2010, 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. In addition to long waiting periods for community-based outpatient services, service gaps and significant wait lists exist for supportive housing, concurrent and dual diagnosis programming, and 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:

Several years ago, North York General Hospital implemented an emergency department diversion project focused on helping people with mental illness. During the 2010/11 fiscal year, 91% of people using this program had no mental health-related return visit to the emergency department within 28 days, representing a 53% reduction in the revisit rate. 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. Following the success of the program, in 2011, Central LHIN partnered with the Mental Health Commission of Canada to develop an enhanced anti-stigma pilot program called Understanding Stigma Phase II: Building Organizational Capability and Driving Sustainable Change.

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. Currently, 10% of the clients who receive short-term case management services through the hubs do not go onto the long-term case management waitlist – demonstrating a diversion from the more intensive services.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal 1

Implement emerging and provincial mental health and addiction priorities.

Consistency with Government Priorities:

Central LHIN goals and priorities are consistent with the provincial government's comprehensive Mental Health and Addictions strategy that includes improving the health and well-being of all Ontarians, reducing the incidence of mental illness and addictions, identifying mental health and addictions early and intervening

appropriately, and providing high quality, effective treatment.

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.		
	2012-13	2013-14	2014-15
Implement applicable/approved strategies from Ontario's Comprehensive Mental Health and Addictions Strategy	10%	TBD	TBD
Implement the Behavioural Support Ontario (BSO) initiative in accordance the Central LHIN Local Action Plan	100%	TBD	TBD
Support the implementation of electronic standardized assessment tools for community mental health programs such as, the Ontario Common Assessment of Need (OCAN) and the Integrated Assessment Record (IAR), and support the shared assessment initiative consistent with provincial priorities	50%	25%	25%

How we will measure success

Behavioural Support Ontario project timelines met for all initiatives

OCAN and IAR are implemented in self-identified health service provider organizations

What are the risks/barriers to successful implementation?

Complexity and number of planning initiatives

Stakeholder engagement may be variable

Recruitment and retention of health human resources to support new initatives

Key enablers

Continued comprehensive and effective engagement with health service providers

Clear vision, timelines and funding for e-tools

Goal 2

Reduce the critical service gaps and improve transitions across the continuum of care.

Consistency with Government Priorities:

Central LHIN goals and priorities are consistent with the provincial government's comprehensive Mental Health and Addictions strategy that includes improving the health and well-being of all Ontarians, reducing the incidence of mental illness and addictions, identifying mental health and addictions early and intervening appropriately, and providing high quality, effective treatment.

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.		
	2012-13	2013-14	2014-15
Continue to support the Centralized Access program and explore opportunities to expand the mental health and addictions system access initiative in collaboration with GTA LHINs	25%	25%	25%
Explore opportunities to support youth with mental illness and addictions as they transition from the child/adolescent system to the adult system	25%	25%	25%
Develop a supportive housing plan (permanent and transitional) for people with mental illness and addictions	50%	25%	25%
Conduct a comprehensive analysis of the repeat visits to the emergency department for mental health and substance abuse conditions and support ongoing health service provider quality improvement activities	50%	25%	25%

How we will measure success

Expand scope and number of programs within the Centralized Access program

Supportive housing plan developed

Emergency department analysis completed

What are the risks/barriers to successful implementation?

Multiple and complex change initiatives of health service providers

Sufficient internal resources within LHIN staff to support/facilitate projects
Key enablers
Continued positive engagement with GTA LHINs and associated health service providers Endorsement and support from multiple health service providers to advance transition planning

Goal 3
Build capacity in community mental health and addictions services
Consistency with Government Priorities:
This goal aligns with the Ministry's priority to reduce emergency department wait times, and reduce unplanned emergency visits within 30 days for those with 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.		
	2012-13	2013-14	2014-15
Explore enhancements to community-based crisis support for mental health and addictions	25%	25%	25%
Expand telemedicine initiatives	10%	25%	25%
Explore opportunities to enhance collaboration between primary care and other sectors to increase access and service availability for chronic disease, mental health and addictions services	25%	25%	25%
Subject to the allocation of resources, enhance resources to support high risk populations	25%	25%	25%
Enhance engagement opportunities with those with lived experiences and family members through the Consumer-Survivor Network and other initiatives	25%	25%	25%

How we will measure success

Reduced wait lists for community-based mental health and addictions services

Number of clinical telemedicine events will increase

What are the risks/barriers to successful implementation?

Successful primary care engagement

Timeliness of new funding for community-based services (e.g. mental health nurses in schools)

Multiple and complex initiatives stretching provider planning capacity (with additional initiatives pending)

Key enablers

Comprehensive and effective engagement with health service providers and primary care

Successful implementation of primary care LHIN lead position

Goal 4

Increase awareness of anti-stigma and 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 comprehensive 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.		
	2012-13	2013-14	2014-15
Continue to support initiatives that champion anti-stigma awareness	50%	25%	25%
Explore initiatives that champion cultural diversity training	25%	25%	25%

How we will measure success

Mental Health Commission of Canada timelines/milestones met

Cultural diversity training program plan developed

What are the risks/barriers to successful implementation?

Multiple priorities and change initiatives challenging resources of providers
Key enablers
Comprehensive and effective engagement with providers

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 service inequities and improve access to care with a specific focus in 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. A Central LHIN Health Equity Advisory Network, composed of community members and health service providers from across the continuum of care, provides advice and acts as a resource to the LHIN.

Current Status

In compliance with Schedule B of the Hospital Service Accountability Agreement, hospitals in Central LHIN continue to develop health equity plans that outline targeted priorities for the coming year, as do community service providers per Schedule E of the Multi-Service Accountability Agreement. Improving availability of, and access to, multi-language and interpretation services, as well as enhancing understanding to cultural needs in health service provision continue to be priority areas of focus in the plans.

Key Issues :

Central LHIN is the fastest growing and most diverse LHIN in Ontario. The LHIN has a projected population growth rate of 19.2% over the next 10 years, the highest proportion of immigrants in the province and twice the provincial average of visible minorities (37% of residents are visible minorities compared to Ontario average ~ 20%). These demographic changes, coupled with existing system capacity pressures, are expected to impact overall access to programs and services.

Specific planning areas such as South Simcoe/Northern York Region, where chronic disease prevalence is higher, and North York West, which has socio-economic challenges which affect the health of this population, will experience these challenges uniquely. Access to comprehensive primary care continues to be an area for improvement in these communities.

Additional challenges have also been identified over the past year related to the need for a better system to support individuals who have complex medical and social support requirements living in the community. These individuals are often served by programs funded and delivered by different ministries and gaps in care transitions (both between systems and between multiple providers) are a known issue.

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 became fully operational: 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 became fully operational, one in Sutton and one in North York West.

Central LHIN participated in the Provincial Aboriginal Planning Session held in Sioux Lookout as well as Pan-LHIN Aboriginal Cultural Awareness training

An updated framework and first set of hospital health equity reports were produced. An updated framework and first set of community support service sector health equity plans were produced. Both frameworks were developed collaboratively with health service providers.

The Entité de planification des services de santé en français #4 Centre Sud-Ouest was established and a Joint Action Plan developed.

A Complex Care Engagement Forum (co-sponsored with the Ministry of Community and Social Services and Ministry of Children and Youth Services) was held. A new multi-disciplinary planning group was established as a result of recommendations from the Forum whose purpose is to develop a strategy to improve the delivery of services to people with complex care needs.

A Health Equity Visioning Session was held in partnership with the Department of Equity Studies at York University to identify key priorities for improving health equity in Central LHIN. Based on recommendations from the Session, a new multi-disciplinary planning group was established to advise on the development of a Central LHIN Newcomer Settlement Strategy.

A new Central LHIN Primary Care Community of Practice and a Primary Care Directory of Services were developed.

Two primary care engagement sessions were conducted – the first related to diabetes management for physicians in partnership with the Ontario Medical Association, and the second in collaboration with the residents of Georgina Island related to addressing First Nations' health needs.

Attachment of unattached patients to a primary care provider through Health Care Connect improved by approximately 10% over the past year.

The Health Equity Impact Assessment tool was successfully piloted as part of ongoing LHIN RFP processes and in the proposal for a voluntary integration of St. John's Rehab Hospital and Sunnybrook Health Sciences Centre.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal 1

Increase health service capacity in identified planning areas to address health service inequities.

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.		
	2012-13	2013-14	2014-15
Expand telemedicine initiatives in key areas where access to services is a known concern	10%	25%	25%
Facilitate collaborative hospital capital planning engagement activities specifically related to ambulatory care in identified areas	25%	25%	25%
Working with the Central LHIN Primary Care Lead, continue to identify opportunities to enhance collaboration between primary care and other sectors to increase access and service availability	25%	25%	25%
Collaborate with the Community Partnership Coordinator from Health Force Ontario	25%	25%	25%
Utilize the Health Equity Impact Assessment tool in Central LHIN planning initiatives	100%	TBD	TBD

How we will measure success

Increase access to new Telemedicine initiatives

Develop and implement an engagement strategy related to capital planning with relevant hospitals and other partners

Develop and implement Central LHIN Primary Care Lead priorities and associated work plan

Increase rate of attached patients in Central LHIN

What are the risks/barriers to successful implementation?

Health service provider engagement related to new initiatives may be variable

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

Current LHIN accountability for primary care and physician services is limited to Community Health Centres

Key enablers
Comprehensive and effective engagement with health service providers and primary care providers Successful implementation of LHIN primary care lead position

Goal 2
Continue to implement community engagement strategies across Central LHIN, in particular to improve collaboration with the Francophone and Aboriginal populations.
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.		
	2012-13	2013-14	2014-15
Continue to support knowledge building, information exchange and process improvement regarding Health Service Provider community engagement activities	25%	25%	25%
Collaborate with the French Language Services (FLS) Entity to support implementation of the LHIN-Entity Joint Action Plan initiatives	25%	25%	25%
Explore joint planning initiatives with GTA LHINs, service providers and other partners to increase access to, and capacity of, French language services in Central LHIN	25%	25%	25%
Engage members of the FLS and Aboriginal communities as part of the planning and development of Integrated Health Service Plan 2013-2016	100%	TBD	TBD

Facilitate dialogue and networking opportunities between Central LHIN and the aboriginal community, including by sponsoring one event	25%	25%	25%	

How we will measure success

Continued active engagement with French Language Service Planning Entity and monitoring of Joint Action Plan initiatives

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

Engagement strategies developed for the French and Aboriginal communities, including as part of the planning for Integrated Health Service Plan 2013-2016

Health service provider community engagement strategies are developed consistent with the Central LHIN Health Service Provider Community Engagement Checklist

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.

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

Key enablers

Maintenance of effective working relationships with French Language Service Planning Entity

Comprehensive and effective engagement with French and Aboriginal communities

Goal 3

Implement strategies to improve relationships and collaboration across LHINs, local governments and other Ministries to address service gaps and improve transitions and access to care.

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.

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.

	2012-13	2013-14	2014-15
Work with the Complex Care Planning Group to develop a strategy to address local system gaps and barriers and improve the delivery of community based services for people with complex care needs	25%	25%	25%
Work through the Newcomer Settlement Strategy Planning Group to develop a strategy to improve newcomer access to the health system, including through exploring multilingual communication initiatives	25%	25%	25%
Continue to facilitate cross sectoral/cross Ministry forums to coordinate service planning and to inform Integrated Health Service Plan 2013-2016 planning and development	25%	25%	25%
Develop and implement a focused engagement strategy with Public Health	25%	25%	25%

How we will measure success

Develop clear priorities and work plans to guide new Planning Group objectives

Achieve support from tri-Ministry leadership for implementation of Complex Care strategies

Develop and implement at least one cross-sectoral/cross-Ministry engagement event

Develop and implement engagement strategy for Public Health that includes representatives from the York Region, Simcoe and the City of Toronto Public Health Units as well as other Chronic Disease Management and Prevention leadership

What are the risks/barriers to successful implementation?

Need to establish a collaborative framework for engagement with Public Health to facilitate successful collaboration

The complexity of MOHLTC, MCSS, and MCYS program and delivery systems will be a key factor affecting implementation of recommendations related to complex care

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

Key enablers

Endorsement/support from tri-Ministry leadership to advance complex care initiatives

Identification of local champion(s) to facilitate comprehensive and effective engagement with Public Health Units

Template B: LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2010/11 Actuals	2011/12 Allocation	2012/13 Planned Expenses	2013/14 Planned Expenses	2014/15 Planned Expenses
Salaries and Wages	2,590,299	2,391,237	2,544,460	2,569,905	2,595,604
Employee Benefits					
HOOPP	242,763	255,167	271,517	274,232	276,975
Other Benefits	326,655	354,036	245,782	248,240	250,722
Total Employee Benefits	***569,418***	***609,203***	***517,299***	***522,472***	***527,697***
Transportation and Communication					
Staff Travel	12,593	14,863	13,350	14,000	14,000
Governance Travel	5,878	4,243	6,000	6,000	6,000
Communications	37,939	44,481	46,375	45,000	45,000
Others	50,028	50,000	47,500	47,500	47,500
Total Transportation and Communication	***106,438***	***113,587***	***113,225***	***112,500***	***112,500***
Services					
Accomodation	242,485	187,505	236,772	243,875	251,191
Advertising	8,743	13,343	5,400	6,000	6,000
Consulting Fees	53,798	-	40,445	25,000	20,000
Equipment Rentals	19,802	12,939	15,000	16,000	17,000
Governance Per Diems	89,170	62,735	76,000	80,000	80,000
LSSO Shared Costs	359,495	451,995	343,400	343,400	343,400
Other Meeting Expenses	84,157	47,966	121,040	80,000	64,049
Other Governance Costs	47,021	3,545	12,000	20,000	20,000
Printing & Translation	11,508	34,635	44,000	45,000	45,000
Staff Development	34,974	36,088	50,400	50,000	50,000
Other	46,027	72,375	31,200	39,989	31,700
Total Services	***997,180***	***923,126***	***975,657***	***949,264***	***928,340***
Supplies and Equipment					
IT Equipment	1,071	-	5,000		
Office Supplies & Purchased Equipment	24,069	53,462	33,500	35,000	25,000
Total Supplies and Equipment	***25,140***	***53,462***	***38,500***	***35,000***	***25,000***
LHIN Operations: Total Planned Expense	4,288,475	4,090,615	4,189,141	4,189,141	4,189,141
Annual Funding Target			4,189,141	4,189,141	4,189,141
Variance			-	0	0

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

Position Title	2010/11 Actual as of Mar 31/11 FTE	2011/12 Forecast FTE	2012/13 Forecast FTE	2013/14 Forecast FTE	2014/15 Forecast FTE
CEO	1	1	1	1	1
Senior Director	2	1.75	2	2	2
Controller	0.6	0.88	1	1	1
Senior Community Engagment Consultant		1	1	0	0
Corporate Associate	1	1	0.75	0.75	1
EA					
Administrative Assistant	2	1.71	1.5	1.5	1
Senior Planner	3.15	3.14	2.4	2.4	2.67
Planner	2	1	0	0	0
Quality Improvement Facilitator	0.5				
Performance, Contract, & Allocation Business	2	2.00	1	2	2
Performance, Contract, & Allocation Senior Business Analyst	1	1.04	2	2	2
Director	4	3.31	4	4	4
Office Manager	1	1	1	1	1
Communications Manager	1	1	1	1	1
Communications Coordinator	1	0.84	1	1	1
Business/Operations Assistant	1	1	1	1	1
Decision Support Analyst	1	0.58	0	0	0
Senior Coordinators	2	2	2	2	2
Project Coordinator	2	0.75	0	0	0
Flow Coodinator	1	1	1	1	1
Total FTEs	**29.25**	**26.00**	**23.65**	**23.65**	**23.67**

Template D: Communications Plan

Communicating the Annual Business Plan
Purpose of Annual Business Plan:

The Annual Business Plan (ABP) is a key guiding document that is critical to the work of Central LHIN.

The ABP demonstrates progress made toward reaching the Integrated Health Service Plan 2010-2013 goals and objectives; and also provides the opportunity to fine tune strategies for the upcoming year. It provides a framework for communicating to stakeholders the impact local decision making has on health care delivery in our communities.

Why do we do an Annual Business Plan?

Under the *Local Health System 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. The Central LHIN ABP Communication Plan works to enable stakeholder access to our strategic and operational plans.

The document also includes an overview of the activities to support key provincial activities and a management plan to identify the future challenges faced by our health care system.

LHINs are responsible for engaging health care providers, consumers, and the general public in the work that is required to build an accessible and sustainable quality health care system.

The ABP also provides LHIN funding requirements for the next three years with particular focus on the 2012-13 fiscal year.

Target Audiences:

Central LHIN engages with many stakeholder audiences, each with its own, and often differing, understanding of the health care system and the role of the LHIN in funding, planning, coordinating and integrating the system. Stakeholders may be categorized in several categories:

- Ministry of Health and Long-Term Care
- Internal to Central LHIN
    - Board of Directors
    - Senior Leadership Team
    - Staff

- Central LHIN Advisory Networks and Groups
    - Health Equity Advisory Network
    - Emergency Department and Alternative Level of Care Advisory Network
    - Chronic Disease Management and Prevention Advisory Network
    - Mental Health and Addictions Advisory Network
    - Primary Care Action Group

  - Community Engagement Task Group
  - Newcomer Settlement Planning Group
  - Complex Care Planning Group

- Internal to the health care system:
  - Hospitals
  - Central CCAC
  - Long-term Care Homes
  - Community Health Centres
  - Community Service Agencies
  - Mental Health and Addictions Agencies

- External stakeholders
  - MPPs
  - General Public
  - Media

Communications Strategy:

The Annual Business Plan describes many initiatives to advance the priorities of the IHSP and each of these has its own communication strategy. In addition, Central LHIN has an overall strategic communications plan that outlines the various tactics used to communicate with stakeholder groups.

This section of the ABP therefore will focus on the strategy to build awareness and understanding of the ABP among all stakeholder groups.

Stakeholder	Timing	Tactic	Details
DRAFT ABP			
Central LHIN Board of Directors	January 2012	Board Meeting	Full text of draft ABP
Ministry of Health and Long-Term Care	January 31, 2012	Electronic submission	Submission of draft ABP to MOHLTC once approved by the Board of Directors
FINAL ABP			
Central LHIN Board of Directors	May 2012 (TBD)	Open Board Meeting	Full text of the final ABP

Stakeholder	Timing	Tactic	Details
Central LHIN Advisory Networks and Groups	Upon Ministry approval	Meetings	Summary presentation plus full text of ABP
Hospitals/CCAC/LTC/CHCs Community agencies/MH&A agencies	Upon Ministry approval	Email notification	An email, from the LHIN CEO, including attachment of full text ABP, in advance of public posting

MPPs			
Media/General Public	Upon Ministry approval	Posting on LHIN website with web alert	Simultaneous posting by all LHINs of MLPS and ABP

Part 2 – Communication Plan for Specific Initiatives

While the LHIN system enables health planning to address local issues, there are a number of common initiatives and platforms that can best be addressed in a coordinated and consistent fashion. To support these activities, and to enhance awareness of the LHIN role with key stakeholders, LHINs, with the support of the Ministry of Health and Long-Term Care, have worked together to ensure a consistent overarching communication plan and branding approach to support the following key provincial priorities:

1. **Home First** – Home First is a philosophy and common understanding that when a person enters a hospital with an acute episode, every effort is made to ensure adequate resources are in place to support the person to ultimately go home on discharge, if appropriate. Home First is intended to:
   - Reduce ALC days in hospital. ALC means that clients no longer require acute hospital care but because there is no other care option available they remain in hospital. In the past, ALC clients normally waited in hospital for a long-term care bed.
   - Provide care to post-hospital patients to continue their recovery at home.
   - Allow clients/families the time to determine if remaining in their home or community is an option, or if other care options are required.
   - Avoid premature admission to long-term care from hospital

2. **Senior Friendly Hospitals** – Research shows that seniors are more vulnerable to adverse events and complications the longer they stay in hospital. They have a two-fold risk of adverse events (e.g., falls, pressure ulcers, surgical complications, and hospital acquired delirium). One-third of frail seniors lose independent function as a result of hospital practices. These risks increase the likelihood that seniors will not be able to be discharged and will become ALC.

   The Senior Friendly Hospital Strategy strives to foster hospital environments that respond to seniors' physical and mental health needs, promote good health (e.g., nutrition, physical activity), are safe (e.g., prevent drug interactions, infections, falls), and involve seniors, their families and caregivers fully in the client's care. After their acute care is completed, seniors regain their health so that they can transition to the next level of care – post acute, home, community or long-term care.

3. **Provincial Falls Prevention Strategy** – In September 2010, falls prevention was identified as a top priority by the Ministry of Health and Long-Term Care. In response, the Integrated *Provincial Falls Prevention Project* was initiated as a LHIN-priority project, in partnership with Ontario's Public Health Units.

   The *Integrated Provincial Falls Prevention Framework & Toolkit* was developed to improve quality of life for Ontario seniors aged 65 years and over, and to lessen the impact of falls on the health care system by reducing the number and impact of falls.

4. **Resource Matching and Referral** – Some of the most significant quality care issues occur in transition points in the health care system as patients/clients move from one provider to the next. In the absence of an electronic system to support patient referrals, health care providers frequently base referrals on incomplete knowledge of available services and significant time and resources are spent on the administrative burden of completing and faxing multiple forms.

   To address this issue, Ontario's LHINs are working towards an electronic referral information solution based on a system first introduced in Central LHIN. A Resource Matching & Referral (RM&R) system expedites referrals and matches individuals to the earliest available services that best meet their needs, improving quality of care and the experience of individuals and families.

5. **Behavioural Supports Ontario** – In January 2010, the Ministry of Health and Long-Term Care funded a working group to undertake the first phase of an Ontario Behavioural Support System (BSS) Project and develop a principle-based Framework of Care. The framework would enhance services for elderly Ontarians with complex and 'responsive' behaviours wherever they live – at home, in long-term care homes or elsewhere. Responsive behaviours are aggression, wandering, agitation as well as others and for many people the trigger for a crisis visit to hospital and transfer to long-term care.

6. **CCAC Expanded Role** – In 2010, a LHIN/CCAC working group was established to define a consistent/common approach to ensuring legislative changes to enable an expanded role for the CCAC. This group defined how the expanded role should be implemented, outlined what needed to be done consistently across the LHINs and what flexibility would be required for local implementation.

   The working group concluded that a more global review of the CCAC's role was needed and it was agreed the focus of their work would be on:
   - Defining a vision and directional plan for an expanded CCAC role within an integrated system; and,
   - Developing a practical framework to support the consistent implementation of the CCAC's expanded role in placement.

In late 2010, the 14 LHIN and 14 CCAC CEOs agreed upon carrying out the following five Directions for Actions:

1. To ensure the right care at the right place at the right time, the CCACs and LHINs are working in partnership to optimize CCAC capacity: i) to be the single point of access for defined health services; and ii) to be a connection for Ontarians to the most appropriate health care services.
2. CCACs will be the single point of access for expanded services for placement (i.e., adult day programs, complex continuing care, rehabilitation and supportive housing/assisted living). Access for placement will incorporate best practices and a standard approach throughout the province. Each LHIN/CCAC will develop an implementation plan for their area.
3. CCACs will be the single point of access for assisted living services described in the Assisted Living Services for High Risk Seniors Policy.
4. The practical steps and success factors identified through a survey and interviews with LHINs and CCACs will be used as a common, practical framework and provincial directional plan to

implement the expanded role of CCACs. Each LHIN/CCAC will develop more detailed directional plans that will include deliverables, responsibilities and timelines.

5. Each LHIN/CCAC will determine whether to implement the opportunities associated with new prescribed services, new care settings, and use of therapy/assistants/aides given that these implementations are highly dependent on local needs and circumstances (e.g. availability of health human resources, financial constraints). The CCACs will share best practices information to build on others' successes.

Communicating the Provincial LHIN Priorities:

The overarching communications plan is a shared responsibility between the 14 LHINs, the MOHLTC and the Minister's Office. The plan speaks to both a shared communication strategy and communication and operational activities to be undertaken by all LHINs, specifically related to a number of LHIN priority projects. It is the platform upon which the LHINs reinforce the LHIN brand and value of the organizations in leading the important transformation of Ontario's health system.

It is to be noted that the progress of programs supporting the provincial LHIN priorities varies among the LHINs. For example, one LHIN may be deeply entrenched in one priority while at the planning stage of another. For this reason, the overarching plan provides commonality from which each LHIN can then develop a local communication plan for specific initiatives. However, the communications objectives, target audiences, and key messages developed in the overarching plan are to be incorporated into every local communications plan.

Strategic Objectives:

- Raise the profile and demonstrate the value of LHINs at a provincial level
- Create a communications campaign that highlights LHIN initiatives and promotes the value of LHINs for Ontarians
- Campaign is focused on "Access to Care"

Audiences:

- Public (taxpayers, patients/clients and family members)
- Health service providers (funded and non-funded such as public health)
- Physicians (specialists and general practitioners)
- Local government stakeholders (municipal and provincial)
- Premier
- Minister of Health and Long-Term Care
- Minister's Office
- Ministry of Health and Long-Term Care
- Media

Central **LHIN**