Toronto Central **LHIN**

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Ken Deane
Assistant Deputy Minister
Health System Accountability and Performance Division
Ministry of Health and Long-Term Care
80 Grosvenor Street
5th Floor, Hepburn Block
Toronto ON M7A 1R3

Dear Ken,

I am pleased to present you with the Toronto Central LHIN's Annual Business Plan for 20010/2011. This is the LHIN's plan for how we will operationalize and deliver on the priorities in the Integrated Health Services Plan next fiscal year.

The Annual Business Plan sets out a focused set of action steps designed to achieve the Toronto Central LHIN's priorities: reduced ER wait times and ALC days, diabetes, mental health and addictions, and value and affordability. The plan also articulates the expected impacts and, wherever feasible, will use outcomes measures to evaluate and communicate results. For each of the priorities, the Annual Business Plan identifies risks, challenges and mitigation strategies for achieving results by the end of 2010/11.

We look forward to the Ministry's feedback on the plan and to continuing to collaborate with the Ministry, other LHINs, and health service providers and communities in Toronto Central to deliver on the Annual Business Plan for the people we serve.

Sincerely,

Matthew Anderson
Chief Executive Officer

Ontario
Local Health Integration Network

ANNUAL BUSINESS PLAN 2010/11

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Transmittal Letter

Mandate

The Toronto Central (TC) LHIN's long-term vision is shared by all 14 LHINs and embodies the expectation of a health care system that all Ontarians can count on regardless of their individual circumstances and where they live: *A health care system that helps people stay healthy, delivers good care when people need it, and will be there for our children and grandchildren.*

Overview of current programs

The Toronto Central LHIN has the highest concentration of health services in Canada, with 177 agencies many of which provide more than one service, and more than 42,000 health care workers. The LHIN's size is reflected in its base budget of $3.96 billion, provided by the Ministry of Health and Long-Term Care.

With this budget, Toronto Central LHIN is responsible for funding:

- 18 hospitals with a total of 2.2 million total patient days
- 18 community health centres (CHCs) providing 259,400 primary care visits
- 68 agencies to provide community support services (CSS) to an estimated 666,270 visits
- 66 organizations that provide mental health, addictions and problem gambling services
- 1 community care access centre providing 2,878,600 visits/hours of care and case coordination
- 37 long-term care homes accounting for almost two million resident days

A complex range of services spread unevenly across the LHIN

A large number of health organizations operate in the region; not all funded by the Toronto Central LHIN. For example, physicians bill directly to OHIP. While the diversity of services respond to the unique community needs in the LHIN, the complex range and number of services in the Toronto Central LHIN present challenges in bringing organizations together and coordinating care when clients are transferred from one agency to another. Uneven distribution of health service providers across the LHIN is also a problem that leads to inequitable access to care for Toronto Central residents. For example, there are fewer diabetes education programs and centres in the North West and North East of the LHIN – areas which also have the highest rates of diabetes. To address this the LHIN will focus on adding services and better coordinating existing services so as to reach population groups living in areas identified as high-need.

By the numbers: Toronto Central LHIN health service providers

Table 1: Health Service Providers Within the Mandate of the Toronto Central LHIN, 2009*			
Health Service Organizations	**# of Orgs**	**Ministry of Health and Long-Term Care Base Funding (Million)**	**% of Total Base Budget of the Toronto Central LHIN**
Community Care Access Centres (CCACs)	1	$ 167,403,288	4.2%
Community Health Centres – (CHCs)	18	$ 65,789,688	1.7%
Mental Health: Addictions, Supportive Housing, Community Mental Health	66	$109,003,825	2.7%
Community Support Services including Acquired Brain Injury, Assisted Living in Supportive Housing	68	$ 78,773,020	2.0%
Long-Term Care Homes	37	$ 224,026,127	5.6%
Hospitals	18	$ 3,322,753,716	83.7%
TOTAL	208	$ 3,967,749,664	100%

*Does not include enhancements, wait times, Accord funding, etc.

Assessment of Issues and Cost Drivers:

a) Assessment of Issues Facing the LHIN

Inflationary pressures and Balanced Budget Challenges **-** Increased funding allocation targets as provided by MOHLTC will not be sufficient to maintain the current level of services that are provided on a per capita basis in the LHIN.
Aging and Diverse Population **-** Toronto Central LHIN is a region of diversity and extremes and ensuring equity of access remains a challenge.
Insufficient Funding for Priority Programs **-** Toronto Central LHIN provides a large number of priority program services, which are costly to the organizations providing these services, and the demand for these services continues to grow.
High Inflow of Patients from other LHINs **-** Due to the specialized services offered within Toronto Central LHIN, a high inflow of patients from outside the LHIN boundaries seek service in Toronto Central LHIN.
Long-Term Care Home Capacity **–** Wait lists for long-term care in Toronto continue to grow, with 19% of people on the wait list having at least one behaviour that is characteristic of hard-to-place patients. At the same time, several long term care facilities in the LHIN are contemplating closure due to financial challenges.
Overcrowded Emergency Departments and related ALC Challenges **-** In Toronto Central LHIN hospitals in July 2009, patients who need to be admitted spend 16.4 hours on average in the Emergency Department, while those not requiring admission spend 4.5 hours. Toronto Central LHIN EDs have the longest total wait times in the province. Seniors account for approximately 22% of all ED visits in the LHIN. Toronto Central LHIN's Alternative Level of Care days account for 10.6% of total patients days in local hospitals (acute, rehab, and complex continuing care) which translates to more than 500 ALC patients waiting each day for services to become available.

CORE CONTENT

Implementation Plans

PART I: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Reduce emergency room (ER) wait times and alternative level of care (ALC) days.
IHSP Priority Description:
When patients wait for hours to get emergency care or are stuck for days in a hospital bed because they can't get the services they really need, then that tells us the health system is not working the way it should. While there are various and complex reasons for these delays, one of the main reasons emergency departments get backed up is that the hospital beds needed by ER patients are occupied by "alternate level of care" patients waiting to be transferred to a more appropriate care setting. By working to reduce ER wait times and ALC days, the LHIN will address many other problems in the local health system and bring about system-level improvements. The LHIN will also promote equitable access to care by targeting improvements so that those who are most vulnerable and sick get timely access to the care they need. Key to this strategy is targeting those who have mental illness and/or addictions including frail, marginalized, and at-risk seniors, many of whom are homeless or under housed, living in poverty and/or are new immigrants. These population groups make frequent and regular use of ER and inpatient hospital services.
Current Status
Scope of services In the Toronto Central LHIN there are seven acute care hospitals with emergency departments. Each of these hospitals is working towards reducing emergency room wait times, and decreasing the volume of ALC days. There are eight rehabilitation and Complex Continuing Care organizations in TC LHIN who accept clients from TC LHIN hospitals, as well as from other LHINs. These organizations are engaged in their own ALC efforts to increase patient flow. Community-based organizations in the LHIN also support patient populations who are increasingly becoming more complex and require more acute care. *Number and type of clients serviced annually:* For the year 2008-2009 there were 442,695 visits to the emergency rooms in the TC LHIN including the emergency rooms of the Hospital for Sick Children, the Centre for Addictions and Mental Health (CAMH) and the Women's College Hospital's Urgent Care Centre. 19% or 84,478 visits from seniors (including visits to CAMH and the Urgent Care Centre), and 8% of visits were due to mental health issues, addictions, or chronic diseases. Approximately 10% of all acute beds are taken up by ALC patients and 77% of all ALC patients are seniors.

Key issues facing this client group

Each day, hundreds of people who visit Toronto Central LHIN hospitals' emergency departments end up waiting for hours before they're discharged or admitted. In Toronto Central LHIN hospitals in July 2009, patients who need to be admitted spend 16.4 hours on average in the Emergency Department, while those not requiring admission spend 4.5 hours.

One problem in particular that contributes to delays in ER is that many hospital inpatient beds are occupied by "alternative level of care" (ALC) patients waiting to be transferred to a more appropriate setting such as long-term care or home care. In Toronto Central LHIN, where ALC days account for 10.53 per cent of total patient days, more than 500 patients each day are in hospital waiting to be transferred to another care setting.

Successes of the past year

To reduce ER wait times and ALC days, Toronto Central LHIN introduced two programs in 2008: ER Pay for Results (P4R), which provides financial incentives to seven hospitals to meet ER wait times targets, and Aging at Home, which is designed to expand seniors' access to home care, community services and supportive housing and create locally-driven health care approaches to enhance seniors' independence and health status.

So far, these programs have yielded concrete and positive results. Between April 2008 and February 2009, ER wait times improved progressively for patients with relatively minor and uncomplicated conditions as well as for those with more serious conditions that required admission to hospital.

In its first year (2008/09), Aging at Home helped just under 2,500 seniors through 17 locally-driven initiatives. In 2009/10 Aging at Home investments will directly benefit some 5,350 seniors and reduce ALC once initiatives are fully implemented.

PART II: GOALS and ACTION PLANS

Goal (s)

Initiative #1: Standardize referral and intake processes to improve the flow of patients to and within community programs.

To achieve this, the LHIN will expand the standard intake and referral process throughout community agencies that provide services to seniors. We will coordinate referrals to community support services in neighbourhoods using the Community Navigation and Access Project model, which enables patients and clients to get all the services they need through one point of access. Hubs will be identified that will provide access to coordinated services to support aging in place and the needs of caregivers. Implement Resource Matching and Referral (RM&R) tool for community services, focusing on supporting clients' transition from acute, rehabilitation and complex continuing care to community settings and transitions within community programs. Resource Matching Referral is an electronic referral system that matches clients with the most appropriate service.

Initiative #2: Enhance community based programs and services to support patients at home.

To achieve this the Toronto Central LHIN will expand and enhance intensive case management programs, focusing initially on at-risk groups such as frail seniors and clients with addictions. These programs would include ongoing intensive support and flexible packages of community based services to help at-risk

populations transition and remain home after a hospital stay. We will enhance supportive housing services to support newly identified at-risk clients and expand convalescent care to ensure seniors who are transitioning back to their homes and communities are able to function in their daily lives. **Initiative #3: Improve hospital processes to increase capacity in the emergency department.** In order to achieve this the LHIN will continue to increase efficiency by redesigning hospital processes and ensuring discharge planning is done in the early stage of hospital stays to help people return home or advance to the next level of care sooner. The LHIN will increase efforts to identify high-risk seniors to ensure they receive the appropriate services after they are discharged from hospital. Finally we will enhance care of seniors within hospitals to increase their ability to transition safely from the hospital and into their community. Examples of enhanced care may include wound prevention and assistance with continence, walking and nutrition.
Consistency with Government Priorities:
These actions address critical local health care issues while contributing to the provincial priority to address ER wait times and ALC as a key contributor.

Action Plans/Interventions			
Action Plans/ Interventions:			
	2010-11	2011-12	2012-13
Standardized intake in place for all seniors clients of CSS agencies and engage 80% of TC LHIN organizations in the *RMR* program	30%	30%	40%
Put mechanisms in place to identify at risk seniors in all acute care hospitals, and subsequently expand to at-risk individuals in additional sectors	40%	40%	20%
Expand *Integrated Care Model* (ICM) to involve all acute care hospitals, and subsequently expand to include other settings and/or populations	50%	50%	-
Enhance community capacity to support transition of seniors from ER/ALC	100%	-	-
Identify priorities for reducing risk of functional decline for seniors while in acute care, and incorporate into the hospital accountability agreements (HSAAs).		100%	
Ongoing process redesign activities and focus on discharge planning enabling all hospitals to meet ER and ALC targets	70%	30%	

Expected Impacts of Key Action Items
By the end of three years, most people will be treated in the ER or admitted from the ER within the province's wait time targets. More people will receive timely access to an enhanced range of services that meet their individual needs, particularly those with the highest needs who face - the frail elderly, people with mental illness and/or addictions and people with complex chronic conditions. Outcome metrics: Proportion of Admitted patients treated within the Length of Stay (LOS) target of ≤ 8 hours. Proportion of Non-admitted high acuity patients treated within their respective targets of ≤ 8 hours for Canadian Triage and Acuity Scale - CTAS I - II and ≤ 6 hours for CTAS III Proportion of Non-admitted low acuity patients treated within the LOS target of ≤ 4 hours Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment. Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment.

What are the risks/barriers to successful implementation?

Risk	Mitigation strategy
There are significant process and culture change initiatives across multiple organizations and multiple sectors.	Successful change will take time and requires leadership support across all HSPs. TC LHIN will take a role in bringing leaders together to develop common understanding of LHIN goals, and develop shared approaches to making change.
All hospitals (acute, rehab, CCC) in TC LHIN continue to be challenged in reducing high ALC days.	Multiple strategies will be taken to deal with the flow of ALC patients. These include Aging at Home investments to transition patients from hospital to community, and improvements to discharge planning. RM&R is key to patching patients with appropriate services outside of acute care.
Impacts of activities may not show quick results in ER and ALC indicators	Drive change as quickly as possible in order to achieve impacts, and strive to have performance measured in ways that allows gradual improvements to be recognized.

PART I: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Improve the prevention, management and treatment of diabetes.

IHSP Priority Description:

Focusing on diabetes as a strategic priority for the LHIN will both improve health outcomes for people with this disease and prevent people with diabetes from getting sicker with other conditions. By acting on this priority, we will reduce the demand on our health system by helping people with diabetes manage their disease and prevent the onset of other diseases.

Making diabetes a strategic priority will also enhance health equity in the Toronto Central LHIN since diabetes disproportionately affects visible minorities, low-income groups and marginalized populations in our communities. For example, 10 to 20 % of the region's South Asians and 22% of Aboriginal people aged 65 and older have diabetes.

Current Status

Diabetes services in TC LHIN

There are currently several types of diabetes programs in the TC LHIN: 14 MOHLTC-funded Diabetes Education Programs, approximately 13 hospital-based diabetes education programs, as well as both diabetes education centres and clinics which are most often found in hospitals or as part of Family Health Teams. Diabetes education programs provide group classes and one-on-one individual education and counseling as well as outreach and clinical management with medical directives whereas diabetes clinics are most often a one-stop-shop and include all necessary specialists under one roof. TC LHIN is also home to four MOHLTC-funded Chronic Kidney Disease regional programs that offer home and onsite dialysis services to patients from all across Ontario.

General Practitioners and Family Physicians are the main providers of primary care for people living with diabetes. Approximately 44% of adults living with diabetes in the TC LHIN (33,407 adults) are rostered to a primary care enrollment model (excluding CHCs) and most are registered to a Family Health Group. It is also important to note that though studies have shown that people with complex diabetes who see specialists have better health outcomes, the majority of people with complex diabetes in the TC LHIN are being managed by primary care practitioners. These results underscore the need to ensure that education be made available in order for primary care practitioners to have the knowledge to better manage the complex care of these patients.

Key issues and types of clients served

Rates of diabetes in Ontario increased 69% over a 10-year period, and this disease represents the fastest growing chronic illness in the province. It is estimated that 46% of the TC LHIN's population aged 12 and over are physically inactive and over 40% of those aged 18 and over are either overweight or obese. The combination of more people being obese at a younger age, growing rates of diabetes and an aging population, indicate that there is an unprecedented demand for effective management of chronic disease: 31% of residents (363,000 people) have at least one chronic disease and rates are higher among seniors; 1/4 hospitalizations, 1/10 ED visits and 1/5 visits to general practitioner/family physicians are due to management of chronic disease.

Although Toronto Central LHIN has the highest physician to population ratio in Ontario, there is a considerable proportion of the population without regular access to a physician. Approximately 12% of people aged 12+ reported not having a regular medical doctor compared to 9% in Ontario; 19% did not have contact with medical doctors. These proportions are higher in those with low socioeconomic status and the homeless.

Failure to see a primary care physician in the previous year is often the strongest predictor of having avoidable ED/hospital visits for chronic disease. For diabetes, 13% of people with a primary care physician had an avoidable ED/hospital visit compared to 25% with no such primary care contact.

The north east and north west areas of the LHIN have the highest rates of diabetes in the LHIN. These areas also have the highest number of people with diabetes per diabetes education program, signifying disproportionately higher demand than supply for necessary health care among the highest need population. In addition, a considerable number of people with diabetes are not receiving the recommended standard of care. For example, between 2004/05 and 2006/07, the proportion of the population aged 30 years and older with diabetes in Toronto Central LHIN who had received an eye examination within two years declined from 57% to 50%.

Successes of the past year

Toronto Central LHIN is one of three LHINs designated to spearhead thinking on Ontario's diabetes strategy. In 2009/10 the TC LHIN Diabetes Strategy Steering Committee successfully developed a model of care for diabetes management for the TC LHIN with input from the community and health service providers. This was done under the leadership of Dr Bernard Zinman, Director, Leadership Sinai Centre for Diabetes, Mount Sinai Hospital; Dr Lynn Wilson, Professor and Chair, Department of Family and Community Medicine, University of Toronto; and Lynne Raskin, Executive Director, South Riverdale Community Health Centre. The recommendations from the steering committee have successfully been incorporated into a proposed regional coordinating centre model that the Ministry will be implementing. In addition, the steering committee developed a work plan for a pilot project to improve diabetes management among the Aboriginal population, and provided recommendations for the diabetes registry pilot sites and the LHIN's role in the registry development.

PART II: GOALS and ACTION PLANS

Goal (s)

To improve the prevention, management and treatment of diabetes and reduce complications from other conditions, Toronto Central LHIN has prioritized the following initiatives over the next three years.

Initiative #1: Expand outreach and screening programs, starting with high-needs neighbourhoods.

To achieve this, the LHIN will ensure ongoing screening and outreach in high-needs neighbourhoods and enhance existing diabetes programs by including outreach workers and partnerships with screening programs.

Initiative #2: Increase access to primary care teams -- which include family physicians, nurse practitioners and dieticians -- starting with high-needs neighbourhoods and high-risk groups.

To achieve this, the LHIN will continue the expansion of Diabetes Education Program in high-needs neighbourhoods in the northwest and northeast areas of the LHIN, implement a primary care engagement strategy in high-risk neighbourhoods, and build awareness of diabetes programs and services in the LHIN through communications strategies that include outreach through community groups, media and interactive Web-based tools that direct clients to local services.

Initiative #3: Improve the quality, consistency and comprehensiveness of diabetes in the primary care or physician clinic setting.

In order to achieve this, the LHIN will A) establish a Regional Diabetes Coordinating Centre which supports the dissemination of best practices and innovations, and centralizes client referrals and coordination of care; B) Identify a baseline diabetes dataset -- based on the number of people with diabetes and physician adherence to four evidence-based tests over the past 12 months -- and establish system performance targets. As the Ministry is the designated lead for the diabetes strategy, the Toronto Central LHIN will act in accordance with Ministry direction on these initiatives.
Consistency with Government Priorities:
Over the last 10 years, the number of Ontarians with diabetes has risen by 69 per cent and the province currently spends more than $5 billion a year to treat diabetes and related conditions such as heart disease, stroke and kidney. To improve prevention, management and treatment of diabetes, Ontario is investing $741 million over four years in a comprehensive diabetes strategy. The TC LHIN's diabetes actions will support the implementation of the provincial strategy in Toronto Central and address local community needs and gaps

Action Plans/Interventions			
Action Plans/ Interventions:			
	2010-11	2011-12	2012-13
Building on the success of two newly created outreach and screening programs, the LHIN will expand into additional high needs neighbourhoods in the LHIN.	100%		
Increase access to team-based care through expansion of Diabetes Education Programs beginning with high risk neighbourhoods and populations (eg. Aboriginals)	33%	33%	33%
Establish Regional Diabetes Coordination Centre.	100%		
Establish baseline diabetes dataset, performance targets set, and primary care providers begin to receive reports	25%	75%	

Expected Impacts of Key Action Items
By the end of three years, people with diabetes will be receiving care according to best practices and will receive better quality of care in a coordinated fashion. The LHIN will monitor those indicators that have been identified by the Provincial Diabetes Strategy. Progress related to diabetes will be measured through projects monitored through the Project Coordination Office.

What are the risks/barriers to successful implementation?	
Risks	*Mitigation strategies*
Improved management of diabetes and its related complications depend heavily on primary care which is largely outside the jurisdiction of the LHINs.	Include comprehensive primary care engagement strategies, leveraging LHIN-Ministry steering committees and other bodies to achieve involvement and buy-in from the primary care community.
In order to drive the coordination of diabetes care, the diabetes patient registry needs to be in place.	Execute select local diabetes management initiatives for clients within their own provider setting; delay providing a seamless approach to diabetes care whereby clients can be identified and their treatments can be coordinated across providers.
Impacts of initiatives may not be fully realized in the short-term.	Drive change as quickly as possible in order to achieve impacts.

IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Improve the prevention, management and treatment of Mental Health and Addictions
IHSP Priority Description:
It is estimated that one in five adults will experience mental illness in their lifetime. Of these, three percent of adults will be seriously affected. Some of the most marginalized people in Toronto Central LHIN are living with mental illness and/or addiction. Addressing this priority will allow the LHIN to improve health equity by ensuring at-risk clients get the help they need. Many people with a mental illness diagnosis also have other chronic conditions such as diabetes and cardiovascular disease. People with mental illness and/or an addiction also tend to be frequent users of hospital emergency departments, although their ER visits often result from an inability to access timely and appropriate support in the community. This priority will enable the LHIN to organize community capacity and set service standards while being respectful of people's differences and personal preferences. In turn, work on setting service

standards in mental health and addictions will inform progress in other areas and help find the balance between improving the consistency of evidence-informed service standards with fine-tuning of services to meet individual needs and circumstances.

Current Status

Key issues and types of clients served

Mental illness and addictions services have received less attention than other health issues in terms of funding, research and public profile, yet demand for these services is steady. While improvements are being made to make community services better coordinated and integrated, community care remains significantly fragmented. The TC LHIN has the highest rate for people who have a psychiatric discharge and then revisit the ED within 30 days and also the highest rate for ED visits within 30 days of discharge without admission. Unmet needs for mental illness and/or addictions clients in the community are contributing to long ED wait times and high ALC days in LHIN hospitals.

There is also limited capacity for supportive housing services for clients with mental illnesses and/ or addictions: Over half of the 27 providers of supportive housing services in the LHIN have waiting lists for both initial assessment and service initiation. In November 2009, there were over 1,100 clients waiting for mental health supportive housing services in Toronto Central LHIN. Existing data and reports on the services for mental illness and addictions show that there is limited coordination across providers, which creates duplication and inefficiency of services and poor quality of care.

There are populations in the LHIN that have a greater need for mental illness and addictions services than others. For example, the largest group of people in ALC beds waiting for LTC are people with dementia. There is an opportunity to assist this population in supportive housing. As well, there are known gaps in services for both the youth and Aboriginal populations.

Approximately three quarters of the mental illness, addictions and problem gambling organizations located in the Toronto Central LHIN also serve people who live outside of the LHIN. Many clients with mental illnesses and addictions residing in rural areas relocate to the Toronto Central LHIN where services are more readily accessible, where anonymity is possible and where transportation to health services is available.

Mental Health and Addictions services in TC LHIN

There are 66 organizations in the TC LHIN that are funded to provide mental health, addictions and problem gambling services. Fifty-one of these hospital or community-based organizations provide mental health services including supportive housing while nine provide addiction services and 10 provide both mental health and addiction services. Two of these organizations have the mandate to serve people from across the province. The LHIN funds seven consumer survivor initiatives (CSI) as well as a network lead to plan and coordinate CSI activities and provide input to LHIN planning activities. In addition to challenges with coordination, available services are not well known in other health sectors, which further impacts access to services.

Successes of the past year

TC LHIN has invested in various initiatives to support people living with mental illness and addictions, including the expansion of supportive housing, and outreach services to help seniors with mental illness and/or addictions stay in their community. All 28 mental health and addictions supportive housing providers – comprising nearly 100% of the TC-LHIN funded units for mental health and addictions – have created one wait list and a standard process for client intake and referrals. The TC LHIN has expanded the use of an electronic medical record for the homeless population called Client Access to Integrated Services and Information; over 6,000 homeless clients were registered in the CAISI system in the past year and 37 agencies are using the system. The LHIN developed a transitional unit to help hospitalized seniors with mental health issues return home and created specialized tools and education material to help ER staff identify and assess seniors with mental health and addiction issues, and to link these clients with the appropriate post-ER care.

GOALS and ACTION PLANS

Goal (s):

The overarching objectives for the upcoming three years are to improve access to coordinated and integrated mental illness and addictions services; increase capacity in areas of known need; reduce unnecessary ED visits and hospitalizations beginning with a focus in population groups with the highest needs. To do so, the TC LHIN has prioritized the following initiatives over the next three years.

Initiative #1: Develop and implement initiatives to target the needs of the most complex and vulnerable communities in the Toronto Central LHIN.

The LHIN will identify integration initiatives for each priority population identified in the Toronto Central LHIN Mental Health and Addiction Gap Analysis project (homeless, seniors, immigrants, refugees, aboriginals and children and youth) and test and evaluate population-specific integrated care initiatives that build on existing investments. For example: integrated care and case management team in addictions addressing the needs of most complex and intense service users of ER and of withdrawal management services.

Initiative #2: Implement standardized assessment process in Community Mental Health programs.

The LHIN will implement a provincially endorsed community mental health common assessment tool (OCAN) in targeted mental health services (ACT, Case Management, Clubhouse, Early Intervention, Social Rehabilitation/ Recreation, Support within Housing, Short-term Residential Crisis Support Beds) and initiate the testing of OCAN in additional targeted programs to support priority populations. Examples of such programs would be Counseling and Treatment, Dual Diagnosis, Psycho-geriatric, and Forensic.

Initiative #3: Develop and implement standardized intake and referral process in Mental Health and Addictions programs.

The LHIN will identify and develop tools that screen for specific needs and conditions to ensure clients are being provided the most appropriate service at the most appropriate place. The LHIN will

establish and pilot one common referral form for a defined set of mental health and addictions programs and services to streamline access and provide greater consistency and coordination and begin the sector-wide implementation of the Resource Matching and Referral (RM&R) tool.

Initiative #4: Enhance data collection and utilization in mental health and addictions programs and services to support evidence- informed decision-making.

The LHIN will collect and analyze identified data sets and set baseline performance targets in alignment with indicators for the provincial mental health and addictions strategy.

Consistency with Government Priorities:

The Minister's advisory group on mental health and addictions is now working on a 10-year strategy to address these vital issues. The TC LHIN led community engagement with local consumers and health services providers to inform the province's 10-year strategy and continues to align its activities to support the achievement of the provincial plan.

Action Plans/Interventions			
Action Plans/ Interventions:			
	2010-11	2011-12	2012-13
Using the findings from the TC LHIN MHA Gap Analysis, develop and implement initiatives to target the needs of the most complex and vulnerable communities in the TC LHIN	20%	40%	40%
Implement common intake and referral form for MHA	10%	50%	40%
Implement common assessment tool (OCAN) in the majority of community mental health agencies in TC LHIN.	50%	50%	
Enhance data collection and utilization in mental health and addictions programs and services in order to support evidence informed decision making	20%	40%	40%

Expected Impacts of Key Action Items
By acting on these priorities, more people will mental health and/or addictions issues have quicker and more equitable access to the right mix of services to meet their needs; more clients will move from the streets or institutions into supportive housing; and more clients will actively participate in their care through the assistance of a consumer-led common assessment tool. Metrics: To monitor the impact of mental health and addiction initiatives, the LHIN will strive to meet all targets set out by the provincial mental health & addictions strategy. In addition, the LHIN measure: • % of agencies using OCAN tool • % of agencies using RM&R

What are the risks/barriers to successful implementation?	
Risk	*Mitigation strategy*
Stretched sector, so ability to drive change is unproven	Select health service providers who have high levels of readiness, willingness and proven ability to succeed
High number of disparate health service providers who serve mental illness and/or addictions clients so coordination may be challenging	Focus on discrete areas within the mental illness and addictions sector and begin implementing coordination in areas of most need
Lack of /or poor quality data can prohibit comprehensive monitoring of impact of initiatives	Encourage health service providers to improve data reporting and ensure that all required data are identified and collected throughout the course of the projects.

IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Integrated Health Services Priority:
Improve the value and affordability of health care services
IHSP Priority Description:
With a substantial provincial deficit, creating a more sustainable local health system is now more important than ever. Accordingly, the level of funding for health service providers (HSPs) in the LHIN is uncertain. As a result, HSPs are grappling with whether services will need to be reduced, planned new services need to be delayed, or organizations closed in order to balance financially. The intent of the Value and Affordability priority is to identify and implement plans to deliver current health care services for lower cost without reducing quality. Over time, work of this nature will lead to a dampening of the current cost curve for health care services.

Current Status

Key Issues

Fiscal sustainability is affecting different sectors in a myriad of ways. In the long-term care sector, smaller agencies are challenged as to whether staying in business is financially viable. In the community health centre (CHC) sector, shortfalls in funding from the Ministry may delay opening of projected satellites. In the hospital sector, service reductions are being contemplated in order to balance budgets depending on the level of funding available in 2010/11.. Across all sectors, agencies are looking for ways to increase efficiency in order to reduce costs. And hospitals and other HSPs are discussing together ways to reduce duplication, increase efficiency and look at more cost-effective ways to deliver services while protecting and even enhancing quality.

A critical issue in exploring value and affordability is ensuring the quality of care (or "value") is not compromised. An equally critical issue is that solutions much produce tangible savings to be considered successful. To that end, the LHIN established criteria to guide its value and affordability efforts:

- Impacts more than one organization (ideally, more than two)
- Results in tangible savings
- Results in savings that can be achieved without compromising quality of care
- Results in savings that can be measured
- If investment is required, level of investment should correspond to the level of savings anticipated
- Savings can be realized in reasonable and defined timeframe; ideally, initial savings can be realized within the first three months of the fiscal year

Successes of the past year

In the past year, the LHIN has made progress on Value and Affordability in three primary domains.

- *Focused work on value and affordability in the hospital sector:*
    - Development of six hospital task forces focused on developing solutions relating to: laboratory services, pharmacy services, paediatrics, mental health and addictions, integrated care for complex populations, and clinical utilization/clinical efficiency.
- *Establishing structure, criteria and process to guide value and affordability work*
- *Initiating Value and Affordability discussions with the CHC and CCAC sectors*

GOALS and ACTION PLANS

Goal (s)

To improve the value and affordability of health care in the region over the next three years, Toronto Central LHIN has identified the following initiatives:

Initiative #1: Implement hospital-specific Value and Affordability Task Force business plans

Initiative #2: Develop and implement non-hospital sector plans deriving from community sector task forces

Initiative #3: Develop LHIN-specific obligations in accountability agreements related to CHC-specific V&A recommendations

Initiative #4 Develop LHIN-specific obligations in accountability agreements related to hospital V&A recommendations:

- Energy and environment obligations
- Shared lab governance obligations
- Pharmacy collaboration obligations
- Clinical efficiency and utilization obligations

Initiative #5 Develop LHIN-specific obligations related to CSS, CMH, CAC, and LTC Value and Affordability recommendations

These initiatives will be undertaken using sectoral and cross-sectoral work groups and task forces so as to have solutions driven from the health service providers themselves. The Multi-Sector Service Accountability Agreement and the Hospital Service Accountability Agreement will be used as key levers to entrench the changes required in order to achieve savings.

Work will include an assessment by the LHIN of the most appropriate and cost-effective sectors in which certain services may be provided.

Consistency with Government Priorities:

As a result of the downturn in the economy, the available resources are limited and this has sharpened attention in all sectors on concepts of efficiency, sustainability and affordability. Local efforts to increase the value and affordability of health care services will contribute to the sustainability of the provincial health care system.

Action Plans/Interventions			
Action Plans/ Interventions:			
	2010-11	2011-12	2012-13
Implement hospital-specific Value and Affordability Task Force business plans	70%	20%	10%
Develop and implement non-hospital sector plans deriving from community sector task forces	33%	33%	33%
Develop LHIN-specific obligations related to CHC-specific V&A recommendations: • Back office integration obligations (minimum of one)	70%		30%
Develop LHIN-specific obligations related to hospital V&A recommendations: • Energy and environment obligations • Shared lab governance obligations • Pharmacy collaboration obligations • Clinical efficiency and utilization obligations	70%		30%
Develop LHIN-specific obligations related to CSS, CMH, CAC, and LTC Value and Affordability recommendations	20%	40%	40%

Expected Impacts of Key Action Items
• # of HSPs that have balanced budget • # of structures and processes in place (through collaborative ventures for savings) that poise the LHIN for serious action in 2011/12

What are the risks/barriers to successful implementation?

Risk	Mitigation strategy
Stretched sectors and ability to drive change is unproven .	Select health service providers who have high levels of readiness, willingness and proven ability to succeed.
Legal barriers to consolidating highly regulated services such as lab and pharmacy.	Seek legal advice on how to structure system change in a LHIN environment
Providers walk away from shared initiatives.	Ensure that recommendations are included in the service accountability agreements, integrations, and Memorandums of Understanding.
Business plans do not translate to the anticipated gains.	Methodology to measure savings identified up front. Regular monitoring and evaluation to flag issues earlier and reduce the magnitude of not achieving the results.

ENABLERS:

Health Equity

Health equity is a critical enabler to driving transformation across the TC LHIN's five IHSP-2 priorities. Evidence shows that, on average, individuals who are poor, have language barriers and are newcomers to Canada have poorer health and do not receive the same access to health care as the general population. Health equity is of particular concern in Toronto Central LHIN, where the tremendous range and diversity of incomes, languages, education and other cultural and socio-economic factors have led to inequities in access to services and in health outcomes.

Health equity issues intersect with LHIN priorities significantly. Examples related to diabetes include: prevalence of diabetes in the general population is 8.9% whereas it is 10-20% among the South Asian population; diabetes rates in the lowest income groups (26%) are nearly double the rate in the highest income group (14%);

The LHIN does not have comprehensive data about services that address health inequities in the LHIN. However, within the hospital sector, the hospital health equity plans (developed by all 18 TC LHIN hospitals in 2009), provide an indication of the range of health services designed to enhance access for particular groups, e.g. new immigrants and vulnerable or marginalized groups. As a group, hospitals described a versatile range of approximately one hundred initiatives to improve access to and quality of health care for underserved and underrepresented populations. Examples include outpatient services, outreach services in the home and community, psycho-geriatric services, services that help patients navigate the system, language and communication services, and support services to caregivers.

Drawing on insights from the hospital Health Equity Plans, and on engagement with providers and consumers, the following action initiatives have been selected and outlined in IHSP-2 to improve health equity over the next three years:

- Develop and implement a LHIN-wide language and interpretation model to set standards and achieve consistency in the supports individuals can access for communicating with their care teams.
- Build obligations to promote health equity into accountability agreements starting with Hospital Service Accountability Agreements and extending to other sectors in subsequent years.
- Identify a common set of hospital and system-level data critical to measuring, developing and evaluating strategies to address health inequities.
- Introduce the Health Equity Impact Assessment tool, developed by the Ministry of Health and Long-Term Care and Toronto Central LHIN, into LHIN planning and decision making.
- Develop and implement knowledge translation approaches that encourage the sharing and uptake of best and promising practices among health service providers to support health equity
- Embed health equity within all IHSP-2 priority action plans to ensure a systematic approach to the reduction of health inequities across priorities and target populations

E-Health

E-health is a significant enabler to IHSP-2 strategies in the LHIN. eHealth tools and initiatives have already resulted in significant changes in health care, bringing tremendous advances in patient safety and management of surgical wait times in Ontario. In Toronto Central LHIN, where a multitude of healthcare providers across the system look after the needs of thousands of people each year, using technology to share patient and treatment information can help people get the appropriate treatment faster, reduce duplication of tests and minimize medical errors.

Major Initiatives:

- *Resource Matching and Referral (RM&R)* is an electronic referral system that will improve client/patient transitions from one level of care to the next, most appropriate level of care, based on a standardized assessment of the client/patient need(s). To date,
    - Inpatient medical and surgical units in 6 acute care facilities are using RM&R to refer patients to Long-Term Care, CCAC for in-home services, and rehabilitation hospitals and complex continuing care hospitals
    - 8 rehabilitation and complex continuing care facilities are receiving referrals from acute care, and sending referrals to Long-Term Care via the CCAC using the RM&R system;
    - Toronto Central CCAC using RM&R to receive referrals for Long-Term Care placement and in-home services;
    - 38 Long Term Care (LTC) homes using RM&R to receive referrals from the CCAC for placement.
    - 20,000 health care workers are using the system for referrals.

- *ConnectingGTA (cGTA*) is a solution enabled by information technology that will allow Greater Toronto Area (GTA) healthcare providers to view all relevant healthcare information related to their patients at the point of care by connecting all the disparate clinical information systems of participating healthcare organizations within the GTA. The integration of these systems will improve clinical decision making and the quality of patient care.
- A *Diagnostic Imaging Repository (DI-r)* is a collection of all patients' diagnostic imaging results in single, standards-based repository that would support sharing of images locally, regionally, provincially and on a pan-Canadian basis. The creation of the diagnostic imaging repository is a critical component of the interoperable electronic health record. The repository will provide clinicians access to all patient images and reports acquired at any partner health care facility in the GTA West.
- The Toronto Central LHIN has been selected as a pilot LHIN for the *Ontario Diabetes Registry*, which over the next four years will become a critical tool in identifying people living with diabetes. The Diabetes Registry will provide physicians, nurses and other health care providers with up-to-date, critical health care information they need to manage people living with diabetes. Providers will be able to find out what drugs their patient/client has been prescribed, what allergies might exist, whether they have had appropriate tests and the results of those tests.

Key 2010/11 Activity

- Develop and implement ConnectingGTA
- Develop and Implement GTA West Diagnostic Imaging Repository Project
- Implement Resource Matching and Referral (RM&R) for EDs to community agencies (CSS, CHCs, and CMH); implement bed-level matching functionality for referrals to long-term-care; expand acute inpatient services (beyond General Internal Medicine and Medical/Surgical Inpatient)
- Planning for local implementation of Diabetes Registry; Phase 1 implementation
- Planning for implementation of patient portal

LHIN STAFFING AND OPERATIONS

Template B: LHIN Operations Spending Plan				
LHIN Operations Sub-Category ($)	**2009/10 Allocation**	**2010/11 Planned Expenses**	**2011/12 Planned Expenses**	**2012/13 Planned Expenses**
Salaries and Wages	3,627,169	4,044,918	4,600,337	5,147,844
Employee Benefits				
HOOPP	362,717	404,492	460,034	514,784
Other Benefits	435,260	485,390	552,040	617,741
Total Employee Benefits	***797,977***	***889,882***	***1,012,074***	***1,132,526***
Transportation and Communication				
Staff Travel	43,500	44,370	45,257	46,163
Governance Travel	6,000	6,000	6,000	6,000
Communications	52,000	53,560	55,167	56,822
Other Benefits	-	-	-	-
Total Transportation and Communication	***101500***	***103930***	***106424.2***	***108984.35***
Services				
Accomodation	299,000	349,000	349,000	349,000
Community Engagement	35,000	65,000	66,950	68,959
Consulting Fees	155,000	159,650	207,545	217,922
Governance Per Diems	143,100	143,100	143,100	143,100
LSSO Shared Costs	380,000	391,400	403,142	415,236
Other Meeting Expenses	29,000	29,870	30,766	31,689
Other Gevernance Costs	15,900	16,377	16,377	16,868
Printing & Translation	118,033	100,328	102,335	104,381
Staff Development	35,000	36,000	36,000	36,000
Total Services	***1,210,033***	***1,290,725***	***1,355,215***	***1,383,156***
Supplies and Equipment				
IT Equipment				
Office Supplies & Purchased Equipment	92,142	95,604	97,516	99,466
Total Supplies and Equipment	***92,142***	***95,604***	***97,516***	***99,466***
LHIN Operations: Total Planned Expense	5,828,821	6,425,059	7,171,566	7,871,976
Annual Funding Target				
Variance				

LHIN Staffing Plan

	2008/09 Actual	2009/10 Forecast	2010/11 Plan	2011/12 Plan	2012/13 Plan
Number of FTE					
CEO	1.0	1.0	1.0	1.0	1.0
Executive Assistant	3.0	3.0	3.0	3.0	3.0
CEO Office - Corporate Co-coordinator	1.0	1.0	1.0	1.0	1.0
Senior Directors	3.0	3.0	4.5	4.5	4.5
Receptionist	1.0	1.0	1.0	1.0	1.0
Controller / Business Support Mgr.	1.0	1.0	1.0	1.0	1.0
Office Manager	1.0	1.0	1.0	1.0	1.0
Communications Specialist	1.0	1.0	1.0	1.0	1.0
Media Relations Specialist		1.0	1.0	1.0	1.0
Financial Analyst	1.0	1.0	1.0	1.0	1.0
Sr Integration Consultant	3.0	4.0	4.0	4.0	4.0
Sr Community Engage Consultant	1.0	1.0	1.0	1.0	1.0
Senior Planner	1.0	1.0	1.0	1.0	1.0
Integration Consultant	1.0	2.0	2.0	2.0	2.0
Community Engage Consultant	1.0	1.0	1.0	1.0	1.0
Planner	1.0	2.0	3.0	3.0	3.0
Project Management Coordinator		1.0	1.0	1.0	1.0
Communication Coordinator		1.0	1.0	1.0	1.0
Decision Support Analyst		1.0	1.0	1.0	1.0
Sr Perform Mge Consultant	3.0	3.0	3.0	3.0	3.0
Sr Funding and Alloc Consultant	2.0	1.0	1.0	1.0	1.0
Performance Mgm Consultant	1.0	-		-	-
Funding and AllocationsCoordinator	2.0	1.0	1.0	3.0	3.0
Funding & Performance Management Analyst		1.0	1.0	1.0	2.0
Funding and Allocations Analyst	2.0	1.0	1.0	1.0	2.0
Total	**31.0**	**35.0**	**37.5**	**39.5**	**41.5**

In 2010/11, the Toronto Central LHIN's HR Strategy reflects an increase in FTEs. This increase is the result of the growing reduction in the use of service contracts and secondments. The increase is also intended to support areas of increased growth in scope for the LHIN, such as a growing role in capital planning.

APPENDIX A

PROJECT	KEY TASKS	RESPONSIBILITY	DUE DATE	STATUS	BUDGET
Needs Analysis (in progress)	• Conduct needs analysis at 14 LHIN locations • Seek input of LHIN CEOs into Operational Strategy • Develop operational plan for first four months • Design and implement strategic planning strategy	ED Allan Madden	February 15, 2010		$5,000 (travel)

SharePoint Implementation
(in progress)
	• Meet with current vendor to determine project status and to define scope of work, schedule, budget
	• Provide contractual rationale for continuation of service – develop contract
	• Launch SharePoint portal at two locations by March 31, 2010
	• Implement a business solutions portal that will provide strategic support to LHIN employees
	  ◦ Document management system
	  ◦ Communications portal
	• Build a project team – utilizing Operations team members
	• Provide support to the project team on the implementation of operating practices that will consolidate existing entities into one
	• Engage employees in the development of revised operating practices and change management support
	• Train all frontline employees on revised operating practices
	• Update intranet tool with revised practices and learning material
	Key Project Elements:
	• Functional Specification - What will each LHIN and associated parties will gain out of this project
	• Technical Specification - What is our approach, what (software) will be used how and when
	• Operational Strategy - Roles and responsibilities for each individual who will be involved in the solution - day to day operations map
	• Governance - Current state and future state - controls & guidance that is necessary to get the ROI from this investment
	• Strategy & Execution - Phases and releases, total roadmap, in a KISS (Keep It Simple Stupid) mode
	• Develop a LHIN CEO Presentation (secure buy in for a shared vision)
	• Audit - What is in place and its current state, audit on systems, licenses, infrastructure, SLA's
	• Plan - Detail project plan and resource need with justifications
		PMO
		Dana Saltern
			March 31, 2010		$200,000

PROJECT	KEY TASKS	RESPONSIBILITY	DUE DATE	STATUS	BUDGET
CRM Implementation (in progress)	• Meet with current vendor to determine project status and to define scope of work, schedule, budget • Provide contractual rationale for continuation of service – develop contract • Work with vendor to redefine business requirements • Provide support to the project team on the implementation of operating practices that will consolidate current entities into one • Engage LHIN employees in the development of CRM system • Launch CRM solution at three locations by March 31, 2010 • Train defined employees on use of new system etc.	PMO Dana Saltern	March 31, 2010		$50,000
Performance Module for SharePoint (in progress)	• Meet with current LHIN users of Performance Point • Define user needs and optimal vision for Performance Point • Work with vendors to define business requirements • Develop Performance point solution • Implement Performance Point at Three LHIN locations	PMO Dana Saltern	June 30, 2010		TBD
Employee Survey (recommended)	• Develop an enterprise-wide employee survey • Ensure that CEOs approve the rationale and content • Conduct an employee survey to gauge employee concerns and to build rationale for HR strategy across the LHINs • Provide feedback to the Boards, CEOs and Staff • Build Rationale for HR Strategy and build the impetus for change within the LHINs	HR Bev Mitchell	May 31, 2010		$5,000
Financial/Procurement Systems Rebuild (required)	• Improve internal controls to manage spending and improve financial accountability • Revamp the monthly financial report to meet the needs of internal and external stakeholders • Provide a line-by-line description of consolidated financials • External audit of balance sheet and financial implications • Implement a seamless financial tracking system – from purchase order, contract management to payment of invoices – to be used for internal purposes	Finance and Procurement Shelley Dagorne and Terry Tyshynski	May 31, 2010		N/A

PROJECT	KEY TASKS	RESPONSIBILITY	DUE DATE	STATUS	BUDGET
Procurement System Development (required)	♦ Work with Controller's Committee to process map a perfect procurement system for implementation in the LHINs ♦ Launch redesigned procurement system through SharePoint to the LHINs ♦ Provide procurement SME advice as required	Procurement Terry Tyshynski	September 30, 2010		N/A
CGI Contract Review (required)	♦ Conduct analysis of CGI contract ♦ Define optimal service offerings (internal to external) ♦ Review all options for IT, Finance and Payroll provision to the LHINs ♦ Prepare a business case for RFP – seek approval ♦ Draft the RFP	Procurement Terry Tyshynski	May 31, 2010		N/A
Benefits Program (required)	♦ Define vision for LHIN benefits offerings ♦ Prepare RFP for consultant – go to market – hire benefits consultant ♦ Work with successful consultant to prepare RFP for benefits provider ♦ Go to market – hire provider ♦ Implement benefits best practices	HR Bev Mitchell	September 30, 2010		$25,000
Job Evaluation and Compensation Design (sample)	♦ Implement a job evaluation system for 14 LHINs in line with approved guidelines and HR best practices ♦ Update job descriptions and complete job evaluation for each – develop and implement supporting policies and procedures ♦ Develop competitive new pay bands for all LHIN personnel ♦ Provide retro payments to applicable staff	HR Allan Madden and Bev Mitchell	March 31, 2011		N/A
Health and Safety Program (sample)	♦ Develop and implement a health and safety program for all LHINs – that meets legislative requirements ♦ Train new JHSC members ♦ Introduce policy framework to support the program	HR Allan Madden and Bev Mitchell	March 31, 2011		N/A
HR Policy Rebuild (sample)	♦ Revamp all existing policies and procedures ♦ Create a manager's tool kit of policies and HR best practices ♦ Implement revised policies through SharePoint ♦ Provide training and support to the LHINs during implementation	HR Allan Madden and Bev Mitchell	March 31, 2011		N/A

PROJECT	KEY TASKS	RESPONSIBILITY	DUE DATE	STATUS	BUDGET
Performance Management System (sample)	• Procure a web based application to support an online performance management system • Develop a web-based performance management system that supports the ongoing needs of the organization • Develop and implement supporting policies and procedures including ▪ Performance Management policy and procedure • Develop a "Manager's Guide" and learning materials for front line managers • Train front line managers • Engage staff in the development of SMART objectives and competencies and behaviours • Implement the system through SharePoint	HR Allan Madden and Bev Mitchell	March 31, 2011		N/A
Enterprise Risk Management (sample)	• Develop a framework for ERM • Complete internal survey to gauge current state assessment • Develop and implement a comprehensive ERM program designed to mitigate CW risk	Finance Shelley Dagorne	March 31, 2011		N/A
Orientation Program (sample)	• Develop and implement a standardized orientation program that meets the needs of the LHINs including learning materials, manuals etc. • Upgrade SharePoint with revised materials where required	HR Allan Madden and Bev Mitchell	March 31, 2011		N/A
French Language Services (required)	• Develop an implementation strategy for French Language services that meets the requirements of the Act • Complete all documentation on behalf of the LHINs • Provide translation services as required	HR Allan Madden and Bev Mitchell	March 31, 2011		N/A
PMO (sample)	• Implement an enterprise-wide strategy for the standardized use of project management principles • Implement a PMO portal in SharePoint • Engage LHIN PMO staff in the development of tools and project management best practices	ED/PMO	March 31, 2011		N/A

PROJECT	KEY TASKS	RESPONSIBILITY	DUE DATE	STATUS	BUDGET
Attendance Management Program (sample)	♦ Develop and implement all of the required policy framework for the successful implementation of attendance management ▪ Attendance Management policy and procedure ▪ Emergency Leave policy and procedure ▪ Accommodation policy and procedure ▪ Accident and Illness reporting policy and procedure ♦ Engage the union in the development of the program ♦ Train staff on program requirements ♦ Implement a stand alone system to measure attendance ♦ Provide reports to front line managers	HR Allan Madden and Bev Mitchell	March 31, 2011		N/A
Rewards and Recognition Program (sample)	♦ Develop and implement a rewards and recognition program for all LHIN employees ♦ Engage employees in the development of key principles, and program initiatives ♦ Implement a program that focuses on service, contribution and performance	HR Allan Madden and Bev Mitchell	March 31, 2011		N/A
Office 2007 Upgrade (recommended)	♦ Implement Office 2007 at all LHIN locations ♦ Provide change management support and training	IT/HR Jonathan Lavigne and Bev Mitchell	March 31, 2011		N/A
Balanced Scorecard (sample)	♦ Develop a performance management system (balanced scorecard) that provides metrics for all aspects of organizational performance ♦ Implement the appropriate quality measures at the LSSO ♦ Engage LHIN staff through a cross functional working group ♦ Develop a LHIN-based balanced scorecard ♦ Implement the balanced scorecard on SharePoint	PMO/HR/Fin	March 31, 2011		TBD

LHIN Shared Services Office
Activities and Objectives

Calendar of Objectives and Tasks

	2010												
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
Needs Assessment													
SharePoint Implementation at 2 Sites													
CRM Implementation at 3 Sites													
Performance Portal Implemetation at 2 Sites													
Employee Survey													
Financial Systems/Procurement Rebuild													
HR Strategy Development													
Procurement System Development													
CGI Contract Analysis													
Benefits Program													
Job Evaluation and Comp Design													
Health and Safety Program													
HR Policy Rebuild													
Performance Management Program													
Enterprise Risk Management													
Orientation Program													
French Language Services													
PMO													
Attendance Management Program													
Rewards and Recognition Program													
Office 2007 Upgrade													
SharePoint Implementation - 12 Sites													
Balanced Scorecard													
CRM Implementation - 12 sites													

The fiscal year 2010-11 will be primarily a year of business as usual for the LSSO. It expected that there will be some growth in LHIN employee resources that will impact IT support costs, but these increases are expected in the course of business and there is no significant change expected in user-based IT demands for 2010-11.

A new staffing position will be filled to address LHIN wide procurement guidance needs. The new procurement directive has placed increasing demands on LHIN staff for expertise not currently available within the LHINs and this centralized shared expertise will address LHIN needs.

As well a third lawyer has been budgeted for the Legal Services Branch to address the increasing needs for legal resources for the LHINs.

The LSSO currently (in 2009-10) has 2 major project initiatives underway:
CRM and Sharepoint. It is expected that these will be completed in 2010-11 with money that has been budgeted in projects to complete their deployment.
In addition, the Outsourcing contract with CGI will expire in March 2011 and money has been budgeted in 2010-11 for consulting resources for the RFS for the new Outsourcing contract..

There are no initiatives planned in 2010-11 that will continue beyond the end of the fiscal year. Any new initiatives beyond those identified above will be based on LHIN requirements.

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

Position Title	2008/09 Actuals as of Mar. 31 FTEs	2009/10 Forecast FTEs	2010/11 Forecast FTEs	2011/12 Forecast FTEs	2012/13 Forecast FTEs
Executive Director	1	1	1	1	1
Controller	1	1	1	1	1
HR Manager	1	1	1	1	1
IS Manager	1	1	1	1	1
LSSO Operations Support	1	1	1	1	1
Payroll Administrator	1	1	1	1	1
Executive Coordinator, LLC	1	1	1	1	1
Procurement Specialist			1	1	1
IS Lead	1	1	1	1	1
Project Manager		1	1	1	1
Project Coordinator		1	1	1	2
CRM/SharePoint Configuration Specialist				1	1
HR Administrator				1	1
Financial Analyst				1	1
Executive Assistant - Legal	1	1	1	1	1
Total FTEs	9	11	12	15	16

Procurement Specialist			1	1	1
IS Lead	1	1	1	1	1
Project Manager		1	1	1	1
Project Coordinator		1	1	1	2
CRM/SharePoint Configuration Specialist				1	1
HR Administrator				1	1
Financial Analyst				1	1
Executive Assistant - Legal	1	1	1	1	1
Total FTEs	9	11	12	15	16

APPENDIX B

2010 Annual Business Plan
Key Activities for LHINC

We are still in the process of determining key priorities for 2010/11. We expect to have a complete list of the major initiatives by February 2010 after they have been considered and approved by LHIN CEOs and discussed with LHIN Council.

We currently have four key activities that were started in 2009/10 and will continue in 2010. They are as follows:

- Support for the development of a new service accountability agreements for hospitals and Long-Term Care homes – this activity will be completed in 2010
- Implement a process for developing performance indicators. This activity will only be 50% complete in 2010
- Support for the review of LTC homes funding. This activity will be completed in 2010.
- Support for the consistent implementation of CCACs enhanced role. This activity will be completed in 2010.

LHIN Collaborative (LHINC)
Subject to approval from their Management Committee

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	378,600	551,078	808,122	824,284	840,770
Employee Benefits					
HOOPP	47,325	68,885	101,015	103,036	105,096
Other Benefits	47,325	68,885	101,015	103,036	105,096
Total Employee Benefits	94,650	137,770	202,030	206,071	210,192
Transportation and Communication					
Staff Travel	1,000	0	5,000	5,000	5,000
Governance Travel		0			
Communications		0			
Other Benefits	4,000	0	4,000	4,000	4,000
Total Transportation and Communication	5,000	0	9,000	9,000	9,000
Services					
Accomodation	39,764	69,553	73,210	74,674	76,168
Advertising - includes recruitment services and EPIC	88,800	53,000	10,000	3,000	3,000
Banking					
Payroll	1,000	1,900	1,938	1,977	2,016
Community Engagement					
Consulting Fees- consultants, including web site development in 2009/10	230,000	281,252	100,000	100,000	80,000
Audit	7,000	7,000	7,140	8,000	8,000
Equipment Rentals					
Governance Per Diems					
LSSO Shared Costs	22,200	75,000	45,288	46,194	47,118
Other Meeting Expenses	14,000	800	31,600	40,000	40,000
Other Governance Costs					
Printing & Translation	1,000	0	10,000	10,000	10,000
Staff Development	2,000	0	4,000	5,000	5,000
Contingency	381,435	0	20,200	21,800	18,736
Total Services	787,199	488,505	303,376	310,645	290,038
Supplies and Equipment					
IT Equipment	62,351	43,296	29,048	5,000	5,000
Office Supplies & Purchased Equipment	42,200	149,350	18,424	15,000	15,000
Total Supplies and Equipment	104,551	192,646	47,472	20,000	20,000
LHIN Operations: Total Planned Expense	1,370,000	1,369,999	1,370,000	1,370,000	1,370,000
Annual Funding Target			1,370,000	1,370,000	1,370,000
Variance			0.0	0	0

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

Position Title	2008/09 Actuals as of Mar. 31 FTEs	2009/10 Forecast FTEs	2010/11 Forecast FTEs	2011/12 Forecast FTEs	2012/13 Forecast FTEs
Executive Director	0	1	1	1	1
Executive Assistant	0	1/2	1/2	1/2	1/2
Senior Consultant	0	2	2	2	2
Project Consultant	0	2	3	3	3
Administrative Assistant	0	1	1	1	1
Title 7					
Title 8					
Title 9					
Title 10					
Total FTEs		7.5	7.5	7.5	7.5

Communications Plan

Objectives:

- Inform health service providers, community and other stakeholders in the Toronto Central LHIN about the Annual Business Plan.

- Promote understanding of, support for and involvement in the implementation of the priority initiatives in the ABP.

Target audiences for ABP

Primary
- Ministry of Health and Long-Term Care
- Toronto Central LHIN-funded Health Service Providers
- Toronto Central LHIN community engagement and advisory groups – priority steering committees, Health Professional Advisory Committee, Clinical Services Leadership Team, sector tables, consumer panels, HSP community engagement network, Aboriginal and Francophone planning and engagement groups.

Secondary
- Community groups in Toronto Central LHIN
- General public in TC LHIN
- Patients and families who receive care in the TC LHIN
- Other health care stakeholder groups

Audiences	Tactics	Issues and Opportunities
MOHLTC	Submit report and post on web site once final.	
TC LHIN-funded HSPs	Engagement: Review ideas in plan, provide opportunity for feedback and dialogue through engagement sessions – i.e., HSP Leadership Forum in January 2010. Comuniqué from CEO to announce final MOHLTC-approved ABP; newsletter article; post on web site. Post-release presentations at HSP Leadership Forum, sectoral tables and as part of CEO and senior management HSP presentations and meetings.	Are aware of and have been engaged and contributed to the development of action plans and performance measures for priorities (part of IHSP-2 process). Some sector-specific concerns about change readiness and change management capacity. HSPs indicated in IHSP-2 surveys a high level of support for TC LHIN's priorities as well as health equity and e-health enablers. Value and affordability concept well supported but will require HSPs and

		sectors to collaborate in new ways and agree to change the way they deliver services for the good of the system.
TC LHIN community engagement and advisory groups.	Review ideas in the Plan and work on implementation processes during winter 2010. Comuniqué from CEO to announce final MOHLTC-approved ABP; newsletter article; post on web site.	Are aware of and have been engaged and contributed to the development of action plans and performance measures for priorities (part of IHSP-2 process). Some sector-specific concerns about change readiness and change management capacity. HSPs indicated in IHSP-2 surveys a high level of support for TC LHIN's priorities as well as health equity and e-health enablers. Consumer Panels (Mental health and Addictions, Seniors) and other consumer advisory groups – Aboriginal and Francophone etc. - will be interested in how the ABP activities impact their particular groups and issues and may be frustrated with the pace of change or feel that their specific issues are not being addressed directly.

Top key messages:

The Annual Business Plan sets out specific actions for improving health care services in the Toronto Central LHIN in 2010/11.

This plan involves all the health service providers in the LHIN and is for the people who receive health care in Central Toronto.

The ABP is designed to make the best possible use of the city's great health care resources. At the end of 2010/11, more people in the Toronto Central LHIN will have timely access to the health care options they require. Those with the most serious and complex conditions will receive additional support when they need it.

The TC LHIN will do this by reducing ER wait times, supporting people to leave ALC beds and receive care in their homes and communities; and by better responding to the needs of people with mental health and addictions and diabetes.