

June 21, 2011

Mr. Alexander Bezzina  
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 Mr. Bezzina,

**Re: Toronto Central Local Health Integration Network – Final Annual Business Plan, 2011/12**

In accordance with the requirements of the Local Health System Integration Act 2006, I am pleased to present you with the Toronto Central LHIN's (TC LHIN) Annual Business Plan (ABP) for 2011/2012. This plan outlines how the TC LHIN will operationalize and deliver on Year 2 priorities of the 2010-2013 Integrated Health Service Plan (IHSP-2). The TC LHIN remains focused on delivering results on current priorities while it strives for system transformation.

The ABP sets out a focused set of action steps designed to achieve the TC LHIN's priorities: emergency room (ER) wait times and alternate level of care (ALC) days, diabetes, mental health and addictions and value and affordability. Within each priority, the TC LHIN seeks to improve access, efficiency and value.

We look forward to continuing to collaborate with the MOHLTC, other LHINs, and health service providers and communities in TC LHIN to deliver on the ABP for the people we serve.

Sincerely,



Angela Ferrante

Board Chair, Toronto Central LHIN

**Annual Business Plan: 2011/12**

**Toronto Central LHIN**

**FINAL**

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**June 17, 2011**

## **CONTEXT**

- 1. Transmittal Letter**
- 2. Mandate**
- 3. Overview of Agency's Current and Forthcoming Programs and Services**
- 4. Assessment of Issues Facing Agency**

## **CORE CONTENT**

- 1. Implementation Plan**
- 2. Performance Measures and Targets**
- 3. Proposed operation expenditures, projected revenues, funding requirements**
- 4. Resources needed to meet goals and objectives**
- 5. Initiatives involved third parties**
- 6. Risk assessment and management**

## **LHIN STAFFING AND OPERATIONS**

- 1. Summary of staff numbers; impact of business plan on human resources; compensation strategy**
- 2. Proposed capital expenditures**

## **COMMUNICATIONS PLAN**

- 1. Details of community engagement specific to this Annual Business Plan (ABP)**

## **LSSO and LHINC SUBMISSIONS**

# 1. Context

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## 1.1. Transmittal Letter

## 1.2. Mandate and Strategic Directions

The Toronto Central LHIN's (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.*

## 1.3. Overview of current and forthcoming programs / activities

The TC LHIN has the highest concentration of health services in Canada, with 174 agencies, many of which provide more than one service. The LHIN's size is reflected in its base budget of \$4.2 billion, provided by the Ministry of Health and Long-Term Care (MOHLTC).

With this budget, TC LHIN is responsible for funding:

- 18 hospitals with a total of 2.2 million total patient days
- 17 community health centres (CHCs) providing 319,200 primary care visits
- 69 agencies to provide community support services (CSS) to an estimated 583,700 visits
- 67 organizations that provide mental health, addictions and problem gambling services
- 1 community care access centre providing 2,965,600 visits/hours of care and case coordination
- 36 long-term care (LTC) homes accounting for almost two million resident days

## By the numbers: TC LHIN Health Service Providers (HSPs)

<b>Table 1: HSPs Within the Mandate of the TC LHIN, 2010/11*</b>			
<b>Health Service Organizations</b>	<b># of LHIN-funded programs</b>	<b>Ministry of Health and Long-Term Care Base Funding (000's)*</b>	<b>% of Total Base Budget of the TC LHIN</b>
Community Care Access Centres (CCACs)	1	\$ 181,152,862	4.3%
Community Health Centres – (CHCs)	17	\$ 77,853,890	1.9%
Mental Health: Addictions, Supportive Housing, Community Mental Health	67	\$112,992,511	2.7%
Community Support Services (CSS) including Acquired Brain Injury, Assisted Living in Supportive Housing	69	\$ 80,414,023	1.9%
Long-Term Care (LTC) Homes	36	\$ 236,875,644	5.6%
Hospitals	18	\$ 3,504,318,203	83.6%
<b>TOTAL</b>	<b>208^</b>	<b>\$ 4,193,607,133</b>	<b>100%</b>

\* Only inclusive of base funding transfer payment

^ Some Health Service Providers provide more than one service (e.g. Baycrest is both a hospital and a long term care facility); accordingly there are 174 Health Service Provider entities representing 208 health service providers.

### 1.4. Assessment of issues facing the agency

- ***Inflationary pressures and balanced budget challenges*** - Funding pressures as a result of gaps between 10/11 funding for hospitals, Toronto Central Community Care Access Centre (TC CCAC) and community agencies and funding targets.
- ***LTC home capacity*** – Hard to place patients are a contributing factor to alternate level of care (ALC). For example, 42% of referrals denied to LTC have “behavioural

characteristics” as a factor preventing their placement. In addition, there are issues associated with decanting residents during redevelopment because of lack of space/high occupancy (99%) and high land and construction cost in Toronto.

- ***Increasing cost and demand for provincial programs delivered by TC LHIN hospitals that are provincial resources for all Ontarians*** - TC LHIN provides a large number of priority program services, which are costly to the organizations providing these services. In addition, the demand for these services continues to grow.
- ***High inflow of patients from other LHINs*** - Due to the specialized services offered within TC LHIN, a high inflow of patients from outside the LHIN boundaries seek service in TC LHIN. Forty per cent of ALC patients in TC LHIN hospitals reside in other LHINs.
- ***MRI wait times and difficulty addressing the complex underlying issues***
- ***Overcrowded emergency departments and related ALC challenges*** – TC LHIN Emergency departments realized a 7% increase in volume in 2009/10. This correlated to a year-over-year increase in admission volumes of 5%. With higher volumes and less beds, the local health care system was burdened with an 11% increase in total ALC days. Efforts to address ALC pressures have been successful, but the *net* change has only yielded a 2% increase in the number of ALC discharges.
- ***Funding shortfall for CHC satellites***

## 2. Core Content

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### Implementation Plans

<b>PART I: IDENTIFICATION OF INTEGRATED HEALTH SERVICE PRIORITY</b>
<b>Integrated Health Service Priority:</b>
Reduce emergency room (ER) wait times and alternative level of care (ALC) days.
<b>Integrated Health Service Plan (IHSP) Priority Description:</b>
<p>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, 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 ERs get backed up is that the hospital beds needed by ER patients are occupied by 'alternate level of care' (ALC) patients waiting to be transferred to a more appropriate care setting.</p> <p>By building on the progress to date in reducing local ER wait times and ALC days, the LHIN will continue to address many other problems in the local health system and continue to drive required system-level improvements. The LHIN will continue promoting 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 the continued focus on those who have mental illness and/or addictions, including frail, marginalized, and at-risk seniors; those who are homeless or under-housed; those who live in poverty; and/or new immigrants. These population groups are known to make frequent and regular use of ER and inpatient hospital services.</p>
<b>Current Status</b>
<p><b>Scope of services</b></p> <p>In the TC LHIN, all hospitals (including seven acute care hospitals with emergency departments, and eight rehabilitation and complex continuing care [CCC] organizations) are working to address the LHINs ER and ALC challenges. Community-based organizations in the LHIN also play a key role in supporting patient populations who are increasingly more complex and require more acute care. Initiatives underway are focused on</p> <ol style="list-style-type: none"><li>1) Reducing ER demand (i.e. Outreach teams);</li><li>2) Improving ER capacity and performance (i.e. Process improvement, LEAN); and</li><li>3) Facilitating care in the community (i.e. Home First, Long Stay ALC decant strategy).</li></ol> <p>Cumulatively, initiatives in these areas help towards reducing ER wait times and ALC days.</p>
<p><b>Number and type of clients serviced annually</b></p> <p>Between 2008 and 2009, TC LHIN saw a 6% increase overall in ER visit volumes. Furthermore, MOHLTC data from the Emergency Department Information System (EDIS) for the first two quarters of fiscal 2010 shows that this trend is continuing as the LHIN has seen a 6.7% increase in ER</p>

volumes compared to the first two quarters of fiscal 2009. The increase (10.9%) is within the population of admitted patients (CTAS I-III categories). The LHIN has evidenced a 3.05% decrease in the number of visits that are within the non-admitted patient population (CTAS IV-V categories). An analysis reflects that this decrease is linked to the 65+ population and can be attributed to the Aging at Home (AAH) community capacity initiatives that have been put in place since 2008.

Information from the Discharge Abstract Database (DAD) and the National Ambulatory Care Reporting System (NACRS) Q2YTD 2010 (as cited in Intellihealth) shows that in TC LHIN, seniors represent 19.3% of ER visits and 33.3% of acute hospitalizations. Furthermore, 73% of acute ALC discharges are for seniors.

### **Key issues facing this client group**

Each day, some people who visit the TC LHIN's ERs end up waiting longer than recommended before being discharged or admitted to hospital. Long ER wait times are a symptom of problems in the larger health system. One such problem is that many hospital beds are occupied by patients waiting for a more appropriate ALC which can limit the ability to admit patients arriving through the ER.

### **Successes of the past year**

Reducing ER demand: Despite seeing an increased in ER visits in the CTAS I-III category (10.9%) between 2007 and 2009, the TC LHIN has seen a decrease in the CTAS IV-V category (3.1%). Deeper analysis shows that the decrease in the CTAS IV-V is for those who are over the age of 65+, which speaks to the impact of the LHIN's Aging at Home Investments in reducing ER demand in the LHIN. Outreach initiatives in the LHIN have also helped to reduce ER demand. The LHINs involvement in the Residents First initiatives, which was initiated in 2010/11, is anticipated to help reduce ER demand in relation to transfers from long-term care (LTC) homes in the coming years.

Improving ER capacity and performance: To help reduce ER wait times and ALC days, the TC LHIN has introduced a range of initiatives that are rooted in the ER Pay for Results (P4R) and AAH Programs. These programs and other efforts to reduce ER wait times and ALC days, led to a 43% reduction in ER wait times in TC LHIN hospitals between April 2008 and June 2010 – the greatest improvement of any region in Ontario. 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.

Facilitating care in the community: Home First is transforming the patient experience for ALC patients in acute care hospitals across the TC LHIN who are waiting to be transferred to a more appropriate care setting, such as in their own homes or LTC. This program is resulting in ALC patients getting home faster and safely and, in many cases, remaining home instead of going to LTC homes. To date, the TC CCAC has shown great success in supporting more than 2500 seniors with intensive case management and integrated care team support, enabling them to remain in the community. Furthermore, as a result of this program, over 150 fewer seniors are waiting for LTC from hospital every month – resulting in more acute beds being freed up every month and promoting better hospital patient access and flow. The program has also evidenced over 30% reduction in the

number of applications for LTC from acute care hospitals, an indicator of the impact of change management in TC LHIN hospitals.

The House Calls project is another example of facilitating care in the community through increased capacity. House Calls is a mobile multidisciplinary geriatric outreach and assessment team that offers comprehensive and ongoing primary care together with a broad basket of services to high risk, marginalized and isolated seniors in their home. Approximately 45% of the project's current client caseload are seniors directly transitioned back home from acute care or ER. Since the team is able to visit the client in their home, these high risk clients are diverted from avoidable ER visits, where appropriate. This initiative is a CSS-lead initiative that works in close collaboration with the CCAC in supporting identified clients.

More broadly, AAH investments from 2008/09 to 2009/10 have directly benefited over 11,000 seniors and in 2010/11 AAH is predicted to directly benefit approximately 15,000 additional seniors. Additionally, a number of AAH investments over the last three years have benefited the caregivers, a key resource that supports seniors to remain in the community.

In an effort to help address the LHIN's ALC rate, through the work of the TC LHIN's Long Stay ALC Task Force and subsequent in-depth long stay patient discharge planning reviews conducted by the TC CCAC, the LHIN has started to discharge some of the most complex and 'hard to serve' patients. Of the 148 patients initially identified and reviewed, 105 ALC patients remain in hospital, representing a reduction of 29% in our long stay ALC population. This reduction will incrementally improve as the CCAC continues to work with hospital partners and patients to transition individuals to the right place of care.

Building on the success of the TC LHIN's Senior Friendly Hospital Strategy, this strategy has now been launched province-wide to enhance the care of seniors and reduce the risk of their functional decline while in acute care. Through this implementation, it can be expected that many of the adverse events associated with seniors' hospital stays can be prevented, ensuring that seniors preserve their independence and well-being. It is anticipated that this focus will contribute to decreased lengths of stay, reduced readmission rates, and reduced costs of hospitalization; all of which will help improve hospital ALC rates and position this initiative as a companion strategy to AAH.

Through implementation of the Resource Matching and Referral (RM&R) system, the LHIN has begun to collect evidence and measure process efficiency through analysis of information such as response and decision times for accepting/denying patients to LTC, rehabilitation, CCC, and CCAC in-home services, further contributing to reducing ALC days and hospital ER wait times. RM&R is an electronic referral system that matches clients with the most appropriate service and is a key enabler for improving ER wait times and reducing ALC days. RM&R contributes to reductions in ALC issues by eliminating process inefficiencies in referral and associated decision times, and examining characteristics of patients and clients consistently denied placement to determine sufficiency and appropriateness of existing programs and services.

Recent successes with respect to RM&R include:

1. The implementation of bed-level matching for clients who are being placed in a LTC home. Bed-level matching provides an accurate centralized database of available bed capacity, enabling improved accountability of organizations for their admission and bed matching decisions, faster identification of clients that are difficult to place, and increased transparency during the "bed offer", "bed denial" process.
2. TC LHIN has completed planning for the implementation of RM&R to support the discharge

of seniors from hospital and other acute settings. The planning process requires extensive change management across the system. For example, to be ready to implement RM&R, the seniors' CSS agencies agreed to one referral form for all their services (over 200 different programs in TC LHIN) and all participating agencies and institutions agreed to access enabled through one phone number, and a minimum data set to initiate a referral. RM&R will be live in the community sector in 2011-12.

## 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 CSS in neighbourhoods using the Community Navigation and Access Project model, which enables seniors and their caregivers to access the services they need through a coordinated entry point. Building on the successful implementation of RM&R to date, the LHIN will move to expand the system to community services for seniors. The main focus will be on supporting clients' transition from acute, rehabilitation and CCC to community settings and transitions within community programs. The LHIN will work with the mental health and addictions (MHA) sector to develop a plan to subsequently expand RM&R to include services they provide.

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

Building on the success of programs implemented through the AAH Strategy, the LHIN will focus on sustaining and expanding high performing programs that have contributed to reductions in ALC and ER demand. The LHIN will continue to monitor the effectiveness of innovative initiatives implemented through well established performance measurement mechanisms. The focus will remain on supporting at-risk groups such as frail seniors and individuals with mental illness and/or addictions to remain in the community and/or transition back to the community after a hospital stay. The LHIN will also continue to work with providers to develop and implement initiatives to address recommendations and issues identified through the assessment of the needs of long stay ALC patients across the LHIN with a focus on transitioning these patients out of hospital and on preventing the generation of new long stay ALC patients. This work will initially focus on patients requiring long-term ventilation services, those with mental health and addictions, and those currently residing in rehabilitation and CCC beds. Through the leadership of the TC CCAC, the LHIN will move to implement strategies to trigger the identification of this population to enable proactive intervention.

#### **Initiative #3: Improve hospital processes to increase capacity in the emergency department.**

In order to achieve this, the LHIN will work with its providers to continue to enhance efficiency through the redesign of hospital processes with a focus on 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 build on related recommendations recently highlighted in the Auditor General's Report and work with providers to implement initiatives to address these

recommendations. The LHIN will expand its efforts to identify high-risk seniors to ensure they receive the appropriate services after discharge from hospital. With a continued focus on Senior Friendly Hospital improvements, the LHIN will sustain its efforts to:

1. enhance the quality of care provided to seniors during their hospital stays;
2. reduce risk of functional decline; and
3. support transitions.

The LHIN will also continue to work on improving the flow of long stay ALC patients by facilitating their transition to more appropriate levels of care, and will develop and implement a sustainable model that will support the proactive identification of complex patients that will be difficult to place, before being deemed ALC. The LHIN will continue to leverage the unprecedented information available through the RM&R system to enable this effort. It will continue to monitor referral response times, acceptance and denial rates, and will assess system demand and capacity gaps.

**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			
<i>Action Plans/ Interventions:</i>	<i>2010-11</i>	<i>2011-12</i>	<i>2012-13</i>
Standardized intake in place for all senior clients of CSS agencies and engage 80% of TC LHIN organizations in the <i>RMR</i> program	30% complete	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% complete	40%	20%
Expand <i>Integrated Care Model</i> (ICM) to involve all acute care hospitals and subsequently expand to include other settings and/or populations	50% complete	50%	-
Enhance community capacity to support transition of seniors from ER/ALC	100% complete	-	-
Identify priorities for reducing risk of functional decline for seniors while in acute care and incorporate into the Hospital Service Accountability Agreements (H-SAAs)		100%	
Ongoing process redesign activities and focus on discharge planning enabling all hospitals to meet ER and ALC targets	70% complete	30%	

Expected Impacts of Key Action Items

By the end of three years, more people will be treated in the ER or admitted from the ER within the province’s wait time targets. More individuals will receive timely access to an enhanced range of services that meet their individual needs, with a particular focus on 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.

What are the risks/barriers to successful implementation?

<i>Risk</i>	<i>Mitigation strategy</i>
There are significant and concurrent process and culture change initiatives underway across multiple organizations and multiple sectors.	Successful change will take time and requires leadership support across all HSPs. TC LHIN will continue to provide the leadership in prioritizing and coordinating this effort to help facilitate required changes.
All hospitals (acute, rehabilitation, CCC) in TC LHIN continue to be challenged in reducing high ALC days.	Targeted strategies will be implemented to deal with identified challenges and opportunities. These include leveraging recommendations identified through the recent Long Stay ALC review, and leveraging the available RM&R system level data.
Impacts of activities may not show quick results in ER and ALC indicators	Close monitoring of implementation efforts and proactive risk identification will continue. Will focus on measuring performance in ways that allows gradual improvements to be identified and for progress to be assessed.
Availability of resources to support decanting of long stay ALC patients.	Work with MOHLTC and local providers to identify opportunities to address gaps and identified barriers.

<b>PART I: IDENTIFICATION OF INTEGRATED HEALTH SERVICE PRIORITY</b>
<b>Integrated Health Service Priority:</b>
Improve the prevention, management and treatment of diabetes.
<b>IHSP Priority Description:</b>
<p>2011/12 will include a continued focus on diabetes as a strategic priority for the LHIN with an emphasis on improving health outcomes for people with this disease and preventing people with diabetes from getting sicker with other conditions. By acting on this priority, we will build on our efforts to date to reduce the demand on our health system by helping people with diabetes manage their disease and prevent the onset of other diseases.</p> <p>Through its strategic focus on diabetes, the LHIN will also help enhance its efforts to address local health equity issues as 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.</p>
<b>Current Status</b>
<p><b>Diabetes services in TC LHIN</b></p> <p>There are currently a variety of diabetes programs available across the TC LHIN: 14 sites with MOHLTC-funded Diabetes Education Programs, approximately 13 hospital-based diabetes education programs, as well as both diabetes education centres and clinics (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.</p> <p>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 while 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.</p> <p><b>Key issues and types of clients served</b></p> <p>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</p>

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 ER visits and 1/5 visits to general practitioner/family physicians are due to management of chronic disease.

Although TC 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 ER/hospital visits for chronic disease. For diabetes, 13% of people with a primary care physician had an avoidable ER/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. These areas also have the highest number of people with diabetes per diabetes education program, signifying disproportionately higher demand compared with 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.

### **Successes of the past year**

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 HSPs. Key elements from the model have been implemented across the province and TC LHIN has taken a central role in coordinating the implementation of the five Greater Toronto Area Diabetes Regional Coordinating Centres (RCC) established in 2010/11. The TC LHIN RCC, hosted by the South Riverdale CHC, will make it easier for people living with diabetes to be connected to diabetes education, support services, and secondary prevention care that are culturally appropriate with an overall anticipated outcome of reducing the incidence of diabetes and diabetes-related complications.

In addition, three new diabetes education teams have been implemented in high-needs neighbourhoods identified by the TC LHIN. As well, through AAH funds, the LHIN invested in three screening and outreach teams directed at the following high-needs seniors groups: South Asian, Aboriginal and Caribbean populations. To date, close to 500 people have been identified as at-risk for having diabetes and have been linked to primary care physicians, nutritional counseling services and lifestyle management classes.

## PART II: GOALS and ACTION PLANS

### Goal(s)

To improve the prevention, management and treatment of diabetes and reduce complications from other conditions, TC LHIN has prioritized the following initiatives:

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

To achieve this, the LHIN will monitor the performance of the screening and outreach initiatives implemented in high-needs neighbourhoods to ensure effectiveness and enhance existing diabetes programs by facilitating linkages among screening, intervention and treatment programs.

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

To achieve this, the LHIN will:

1. continue to support the expansion of the provincial Diabetes Education Programs through the identification of high-needs neighbourhoods;
2. oversee the implementation of a primary care engagement strategy in high-risk neighbourhoods; and
3. 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 TC LHIN will

1. continue to support the establishment of the new Diabetes RCCs, help facilitate the dissemination of best practices and innovations, and centralize client referrals and coordination of care;
2. support the provincial effort to develop 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
3. establish system performance targets aligned with those set by the MOHLTC.

As the MOHLTC is the designated lead for the diabetes strategy, the TC LHIN will act in accordance with MOHLTC direction on these initiatives.

Consistency with Government Priorities:

Over the last 10 years, the number of Ontarians with diabetes has risen by 69% and the province currently spends more than \$5 billion a year to treat diabetes and related conditions such as heart disease, stroke and kidney disease. The TC LHIN's diabetes actions will support the implementation of the provincial strategy in TC and address local community needs and gaps.

Action Plans/Interventions			
<i>Action Plans/ Interventions:</i>	<i>2010-11</i>	<i>2011-12</i>	<i>2012-13</i>
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% Complete		
Increase access to team-based care through expansion of Diabetes Education Programs beginning with high-risk neighbourhoods and populations (e.g., Aboriginals) and increase self-management supports.	33% In progress	33%	33%
Establish Diabetes RCC.	100% Complete		
Establish baseline diabetes dataset, set performance targets, and primary care providers begin to receive reports, starting with the Aboriginal population.	25% In progress	75%	

Expected Impacts of Key Action Items

By the end of three years, more individuals at-risk of having diabetes will

- be identified and connected to appropriate supports to prevent the illness;
- be receiving care according to best practices; and
- have received better quality of care in a coordinated fashion.

**Outcome metrics:**

The LHIN will monitor indicators identified by the Provincial Diabetes Strategy with the guidance of the TC LHIN RCC Steering Committee.

What are the risks/ barriers to successful implementation?	
<i>Risks</i>	<i>Mitigation strategies</i>
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-MOHLTC 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.	Continuing to prepare providers for the adoption of the registry: undertake an IT readiness assessment and identifying areas where the LHIN can support the building of a solid IM/IT foundation.
Impacts of initiatives may not be fully realized in the short-term.	Close monitoring of implementation efforts and proactive risk identification will continue. Will focus on measuring performance in ways that allows gradual improvements to be identified and for progress to be assessed.

<b>PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICE PRIORITY</b>
<b>Integrated Health Service Priority:</b>
Improve the prevention, management and treatment of mental health and addictions
<b>IHSP Priority Description:</b>
<p>It is estimated that one in five adults will experience mental illness in their lifetime. Of these, 3% of adults will be seriously affected. Some of the most marginalized people in TC LHIN are living with mental illness and/or addiction. Addressing this priority will support the LHIN's efforts to improve health equity by addressing barriers to access by these priority populations.</p> <p>Many people diagnosed with a mental illness and/or addictions 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 are often due to an inability to access timely and appropriate support in the community. The same can be said for unnecessary use of other emergency services such as emergency management services (EMS), withdrawal management services (WMS) and shelters. It is acknowledged that many people with mental illness and/or addictions would be better served in alternative locations, shifting the emphasis from hospital and emergency settings to the community. Integration of services within a network of care will promote quality services and support better transitions between levels of care and from service to service.</p>

### **Key issues and types of clients served**

The TC LHIN has the highest rate in the province of repeat emergency department visits within 30 days for those with a mental illness or substance use issue. While considerable efforts have been made to understand the issues and to test solutions, the problem is significant and remains steadfast. Repeat ER visits can be seen as a symbol of a number of health and social system issues that require attention. Those issues include: poor transitions from the hospital back to the community; ineffective or inappropriate care for this complex population at the emergency room; lack of access to health services elsewhere, including primary and psychiatric care; and lack of alternative resources within other settings to support crises and after-hours care.

Additionally, it is widely acknowledged that prevention and management of mental illness and addictions are significantly impacted by the social determinants of health and require an integrated and coordinated approach. Key social determinants include affordable and supportive housing, income, and social inclusion. For example, as of December 2010, there were more than 2000 individuals on the combined wait list for supportive mental health housing units. Marginalized populations experience inequities in accessing mental health, addictions and other health services. These populations are often under-housed or homeless, face linguistic and/or cultural barriers, or have life histories that bear the impact of poverty. Better MHA services for marginalized people requires targeted approaches that integrate services across sectors.

Finally, data quality has been poor in the past, hampering abilities to make system and organizational decisions. Factors important to data quality include common tools for data collection, standard definitions, relevant indicators, and practical use for the data collected.

### **Mental Health and Addictions Services in TC LHIN**

There are 67 organizations in the TC LHIN that are funded to provide mental health, addictions and problem gambling services. Forty-five of these hospital or community-based organizations provide only mental health services including supportive housing, 11 provide addiction services only and 11 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**

In order to make progress on these ambitious goals, the TC LHIN has invested in targeted capacity, system coordination and foundational activities.

Early investments in integrated care (e.g., Toronto Community Addictions Team) for the most intensive and complex users of both WMS and TC LHIN ERs have resulted in large reductions in the number of WMS days (47% in Q2 09/10) as well as significant reductions in repeat ER visits (74% in Q2 09/10). Building on this approach, a Homeless Think Tank was held in the Spring with attendance from over 80 multi-sectoral participants to identify strategies to help address repeat visits to ER for those who are homeless and experience mental illness or addictions. A report was generated from

the Think Tank which provided recommendations on key elements, philosophies and potential approaches to resolving the issue of high repeat ER visits for homeless who are experiencing mental health and addictions issues. The Think Tank directly informed three pilots that were implemented by the LHIN in 10/11: Peer Outreach Worker Pilot; Concurrent Disorders Crisis Response and Coordinated Access to Primary Care Clinics for the Homeless. Each pilot is undertaking an evaluation, the results of which will be used to inform future program development.

TC LHIN supported the provincial implementation of the new Addictions Supportive Housing program. To date, 200 units have been allocated to six partnerships focused on providing supportive housing to people with complex addictions, including capacity to service women-led families and people living with HIV/AIDS.

TC LHIN undertook the first phase of the Ontario Common Assessment of Need (OCAN) implementation resulting in 64% of eligible mental health organizations implementing the common assessment tool. Additional planning has also taken place to outline local models for sharing assessment information, service collaborations, privacy and consent, and using the assessment tool in untraditional settings.

The completion of the Service Capacity Overview Project helped confirm the current service capacity of the community MHA system in the TC LHIN. A methodology for determining the required capacity was developed and recommendations were identified to address capacity levels.

Efforts to further coordinate, streamline and organize access points and referrals between MHA services have successfully produced a coordinated access point for MHA supportive housing, the implementation of an access point for primary and psychiatric care through Inner City Health Associates Clinics, and the initial development of coordinated access to case management services.

The TC LHIN MHA's Decision Support Working Group, comprised of decision support leads among TC LHIN MHA agencies, researchers and strategic experts, reviewed the quality issues related to MHA data, and made recommendations for improvements. They also recommended MHA performance and system monitoring indicators in alignment with provincial and LHIN priorities.

## PART II: GOALS and ACTION PLANS

### Goal(s)

The overarching objectives for the three years of the IHSP are to:

1. improve access to coordinated and integrated mental illness and addictions services;
2. increase capacity in areas of known need; and
3. reduce unnecessary ER visits and hospitalizations beginning with a focus in population groups with the highest needs.

To enable this effort, the TC LHIN has prioritized the following initiatives over the course of the plan:

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

Building on activities implemented in 2010/11, the LHIN will continue to identify integration initiatives for identified priority populations highlighted through the recent Gap Analysis project (homeless,

seniors, immigrants, refugees, aboriginals, and children and youth). The LHIN will continue to test and evaluate population-specific integrated care initiatives that build on existing investments such as the 200 new units of addictions specific supportive housing. The LHIN will also work with local providers to address recommendations identified through the Long Stay ALC project in 2011/11 in reference to the needs of patients with mental illness and addictions.

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

The LHIN will complete implementation of OCAN in eligible mental health services. To optimize the use of the tool, a shared assessment model will be tested. The learnings from the use of OCAN within an addictions setting will be shared with provincial committee and local providers.

**Initiative #3: Develop and implement standardized intake and referral process in MHA programs.**

The LHIN will continue to evaluate and build on coordinated access projects aimed at streamlining access, building common tools, and simplifying referral processes.

**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 datasets and set baseline performance targets in alignment with indicators for the provincial MHA strategy. The LHIN will continue with the indicator development work initiated in 2010/11 well as implement recommendations to improve MHA data quality.

**Consistency with Government Priorities:**

The Minister's Advisory Group on the 10-Year MHA Strategy has now released its report, which will be used to guide future strategic implementation plans. While the implementation plan is being developed, the TC LHIN will continue to ensure that priorities and initiatives are aligned with the recommendations from the Report. Additionally, emphasis has been put on impacting the ER/ALC issue, a key MOHLTC priority that is linked to the MOHLTC-LHIN performance agreement targets for MHA.

Action Plans/Interventions			
<i>Action Plans/ Interventions:</i>	<i>2010-11</i>	<i>2011-12</i>	<i>2012-13</i>
<p>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</p> <ul style="list-style-type: none"> <li>• <u>ER Diversion:</u> Evaluate outcomes from pilots and set priorities for program development, knowledge transfer and scaling</li> <li>• <u>Cross sector forums</u> focused on priority populations</li> <li>• <u>Addictions Supportive Housing:</u> Implementation</li> <li>• Implement Quality initiative in designated TC LHIN sites</li> <li>• Implement strategies to address needs of Long Stay ALC patients with mental illness and addictions</li> </ul>	40%  Target exceeded	30%	30%
<p>Implement OCAN in the majority of community mental health agencies in TC LHIN.</p> <ul style="list-style-type: none"> <li>• Shared assessment model pilot</li> <li>• Reports from OCAN generated for monitoring and evaluation</li> </ul>	50%	50%	
<p>Implement common intake and referral form for MHA</p> <ul style="list-style-type: none"> <li>• Enhance Coordinated Access to Supportive Housing model by integrating other MHA supportive housing</li> <li>• Develop plan for coordinated access for mental health intensive case management/assertive community treatment teams in TC LHIN</li> <li>• Develop plan for coordinated access for Addictions Services in TC LHIN</li> </ul>	10%	50%	40%
<p>Enhance data collection and utilization in mental health and addictions programs and services in order to support evidence informed decision making</p> <ul style="list-style-type: none"> <li>• Set performance targets for MHA performance indicators identified.</li> <li>• Implement action plan to improve MHA data quality</li> </ul>	30%	35%	35%

Expected Impacts of Key Action Items	
<p>By acting on these priorities, more people with mental health and/or addictions issues will have quicker and more equitable access to the right mix of services to meet their needs; more clients who require supportive housing services will be housed; more clients will have access to integrated, collaborative care resulting in better outcomes; and providers and the TC LHIN will have access to better quality data to support decision making.</p> <p><b>Metrics:</b></p> <p>The TC LHIN will measure the following MHA performance indicators:</p> <ul style="list-style-type: none"> <li>• Percentage of agencies using OCAN tool</li> <li>• HSP Reporting compliance indicator</li> <li>• Repeat ED visits for MH and Addictions within 30 days</li> </ul>	
What are the risks/barriers to successful implementation?	
<i>Risk</i>	<i>Mitigation strategy</i>
Stretched sector, so ability to drive change is unproven	Select HSPs who have high levels of readiness, willingness and proven ability to succeed.
High number of disparate HSPs 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 HSPs to improve data reporting and ensure that all required data are identified and collected throughout the course of the projects.

<b>PART I: IDENTIFICATION OF INTEGRATED HEALTH SERVICE PRIORITY</b>
Integrated Health Service Priority:
Improve the value and affordability of health care services
IHSP Priority Description:
<p>With a substantial provincial deficit, creating a more sustainable local health system is now more important than ever. Accordingly, the level of funding for HSPs in the LHIN is uncertain. As a result, HSPs are grappling with whether existing services will need to be reduced, planned new services need to be delayed, or programs closed in order to balance finances.</p> <p>The intent of the Value and Affordability (V&amp;A) priority is to identify and implement plans to deliver</p>

current health care services for lower cost without reducing quality or, alternatively, providing an increased level of health care services at no net new cost. Over time, work of this nature will lead to a bending of the current cost curve for health care services.

## Current Status

### **Key Issues**

The mandate of the V&A objectives have been re-positioned from delivering significant savings to delivering new and more efficient processes to more economically utilize existing dollars to provide more services.

The approach in Year 1 was to focus on large-scale efforts that would yield direct and tangible savings. Within the hospital sector, preliminary V&A analysis indicated that TC LHIN hospitals were operating efficiently when benchmarked to other hospitals in the province. Furthermore, in recent years, hospitals had recognized that fiscal pressures would be an ongoing reality and had worked proactively to lower costs through clinical and back office efficiencies. As a consequence, opportunities for significant efficiency savings were restricted to integrating laboratory services, and accordingly, the goals shifted to delivering processes focused on sustainability.

### **Successes of the past year**

The V&A priority is unique to the TC LHIN in IHSP-2. Phase 1 was hospital-focused as the LHIN facilitated reviews and the development of implementation plans to deliver on identified opportunities. The next phase sought to begin implementation of the proposed plans and to expand V&A to the community sector. Implementation continues and commitment from hospitals remains high as it is recognized that endorsed plans deliver outcomes that best serve all stakeholders.

Uptake of self-directed initiatives under the V&A mandate in the community sector was limited due to a lack of collaboration. In the community setting, where resources to assign to such initiatives are constrained; where a wide range of services are provided; and where agencies are often funded from multiple sources, the capacity and motivation to engage in this work was limited. As a consequence, projects were confined to a single initiative where the CHC sector targeted back office integration and initiated the process to combine outsourced IT support among a group of CHCs

However, the LHIN did successfully lead V&A efforts in the community sector with two key pieces of work:

- 1) An analysis of the available resources within the CSS sector. Documenting different models of care, staffing resources and associated client levels. This work will be complete in Q4 and will provide core information as to where like services are being performed. This will enable the determination of which agency is providing similar services at lowest costs and where there may be opportunities to do business differently. With improved information from the community sector, the TC LHIN expects to leverage a number of pathways (RM&R, CCAC referrals) to improve the effective placement of clients in the most appropriate program.
- 2) Additionally, the TC LHIN engaged in a review of the processes and costs related to transportation services provided by the community sector. Current evidence suggests this service is operating at less than optimal efficiency and concurrent initiatives in clinical efficiency/clinical utilization are dependent upon timely access to TC LHIN funded transportation services. This work will also be completed in Q4.

## Summary of the Year Ahead

Phase 3 of Value and Affordability advances work in the hospital sector with a continuation of initiatives that are focused on developing solutions relating to: collaborative laboratory services, integrated care for complex populations, and clinical utilization/clinical efficiency. The TC LHIN will seek to identify and facilitate partnership opportunities between hospitals and the LTC sector based on recommendations from the Long-Stay ALC task force.

Work in the community sector will focus on reviewing and implementing recommendations arising from the community capacity and transportation reviews in completed in 2010/11. In addition, self-directed data standardization work will provide the basis to ensure that clients will receive the most appropriate and cost-effective care provision.

## PART II: GOALS and ACTION PLANS

### Goal(s)

TC LHIN has identified the following new initiatives in 2011/12 to support the value and affordability priority

#### **Initiative #1: Costing of community based services**

In order to understand where resources are being directed in the community sector, and to build the foundation for a more efficient system, a full review needs to be undertaken to cost each program and underscore the variation and variability according to cost. This work will contribute to the data necessary to undertake efficiency transformations in this sector.

#### **Initiative #2: Review of TC LHIN transportation services and implement recommendations for improved services**

According to international models and existing evidence, the transportation services in the TC LHIN are not operating in line with best practices; are not meeting the needs of clients in the LHIN, as told to the LHIN through various community engagement efforts; and all resources are not being used as efficiently as possible. In response to this, TC LHIN will look to the broader health and social system to define what is needed and will work towards implementing a transportation system that meets the needs of healthcare clients in TC LHIN.

#### **Initiative #3: Analysis and implementation of model for improved client hand-offs from CCAC to CSS services**

The transition of clients from one service provider to another presents a risk to the client. When these transitions occur, any gaps in communication can cause breakdowns in the continuity of care and threaten the quality of care a client receives. This can result in readmissions to the hospital due to lack of appropriate support services – an avoidable outcome. In concert with existing collaborative initiatives already underway, TC LHIN will undertake an analysis of the transitions from CCAC to CSS care, and implement a model that ensures the seamless transfer of clients from one sector to another as well as the seamless flow of client information and assessments.

**Initiative #4: Enhance data collection in the community support service and mental health and addiction agencies**

The LHIN's role to provide a system view to effectively manage the outputs of the multiple, diverse HSPs requires consistent data reporting. Currently, value and affordability discussions are hampered by limited comparable information on which to base decisions.

The general issues related to data collection and quality are:

- a. Complexity of reporting within and across sectors and HSPs
- b. Functional centre definitions and standardization across databases
- c. Capturing demographics and client characteristics
- d. Data completeness, consistency and accuracy

To respond to these challenges, the TC LHIN will be engaging the CSS and MHA sectors to ensure reporting standards and information will allow for ongoing benchmarking and comparative analysis between organizations.

With consistent and accurate information from the HSPs, the LHIN will be better positioned for system-level monitoring and decision-making. Additionally, these data will be used to identify opportunities for transformative changes in the system as outliers and potential efficiencies are recognized.

**Initiative #5: Identify and support opportunities for collaboration between the hospital and LTC sector**

Both hospitals and LTC homes can benefit from potential partnership opportunities. Such relationships could ease the burden of ALC on hospitals, and provide relief for LTC homes facing financial pressures. The TC LHIN will work to identify and facilitate relationships beneficial to the healthcare system and the patient/client. For example, under certain conditions, hospitals may be able to move patients to less intensive, more appropriate settings in the LTC sector.

Collectively, these initiatives will be undertaken using sector-specific and cross-sectoral work groups and task forces so as to have HSP-driven solutions. The Multi-Sector Service Accountability Agreement (M-SAA) and the Hospital Service Accountability Agreement (H-SAA) will be used as key levers to entrench the changes required in order to achieve savings.

**Consistency with Government Priorities:**

The health sector consumes a significant portion of the province's deficit budget. Government leaders have articulated the necessity to bend the cost curve and limit the increase in health care spending while still providing services that meet the needs of the population. The V&A priority aims to reconcile these two objectives by facilitating HSP collaboration and efficiency primarily through appropriate placement of care initiatives.

Action Plans/Interventions			
<i>Action Plans/ Interventions:</i>	<i>2010-11</i>	<i>2011-12</i>	<i>2012-13</i>
Implement hospital-specific V&A Task Force business plans	50% Complete	25%	25%
Develop and implement non-hospital sector plans deriving from community sector task forces	20% Complete	40%	40%
Develop LHIN-specific obligations related to CHC-specific V&A recommendations: Back office integration obligations (minimum of one)	50% Complete	50%	
Develop LHIN-specific obligations related to hospital V&A recommendations: <ul style="list-style-type: none"> <li>• Shared lab governance obligations</li> <li>• Pharmacy collaboration obligations</li> <li>• Clinical efficiency and utilization obligations</li> </ul>	50% Complete	50%	
Develop LHIN-specific obligations related to CSS, CMH, CCAC, and LTCH V&A recommendations	20% Complete	40%	40%
Costing of community based services	N/A	100%	
Review of TC LHIN transportation services and implement recommendations for improved services	N/A	75%	25%
Analysis and implementation of model for improved client hand-offs from TC CCAC to CSS services	N/A	70%	30%
Enhance data collection in the community support service and mental health and addiction agencies.	N/A	80%	20%
Identify and support opportunities for collaboration between the hospital and LTC sector	N/A	60%	40%

Expected Impacts of Key Action Items	
<ul style="list-style-type: none"> <li>• Community agencies to provide services to a more complex/higher acuity client population, as determined by an increase in average client acuity measures (InterRAI CHA, MAPLe).</li> <li>• Improved efficiency and utilization of TC LHIN transportation services, indirectly improving hospital programs in stroke and total joint replacement.</li> <li>• Cost of services by community agencies to be benchmarked, for potential subsequent re-alignment of services.</li> <li>• Decant and sustainable flow of appropriate patients from hospital to long-term care.</li> </ul>	
What are the risks/barriers to successful implementation?	
<i>Risk</i>	<i>Mitigation strategy</i>
HSPs may transfer patients/clients to other sectors in an effort to balance budgets; however, the systemic effects of these transfers may not be taken into account.	The TC LHIN will work cross sectorally to develop principles and steps to ensure patients/clients are transferred to the most appropriate and cost efficient place of care with resources.
Stretched sectors and ability to drive change is unproven.	Select HSPs who have high levels of readiness, willingness and proven ability to succeed.
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.

## 2.1. Enablers

### Health Equity

Toronto is a highly socially and ethnoculturally diverse city. It is also a city of increasing disparities particularly between high and low income groups. These trends have major implications for the health of the local population and the health care system.

Addressing health equity is a key strategy for improving the health of the local population and the communities in which they live. This is for the simple fact that when groups and individuals face barriers and receive a lower standard of care, this leads to poorer health, greater strain on the health care resources and ultimately higher costs for worse outcomes.

Four percent of the population accounts for over 80% of the health care costs in the Toronto Central LHIN. Among this 4 percent are some of the most high needs, marginalized people in city including people with serious mental health and addictions issues, the frail elderly and those who are hard to place because of the complexity of their physical and mental health, including people with Alzheimer's and other dementias. By better meeting the health needs of these individuals we can improve the overall health of the population, freeing up resources to reinvest in preventative health and building stronger communities.

In 2011/12, the second year of the Integrated Health Services Plan-2, the Toronto Central LHIN will focus on advancing health equity initiatives identified by local stakeholders during IHSP-2 community engagement sessions and the hospital health equity plans. The Toronto Central LHIN's priority initiatives to help people transition to the best place of care and improve access to mental health and addictions and diabetes services by design target disadvantaged individuals and communities. In addition, the LHIN will continue to use an equity lens in planning and undertaking our work to ensure the needs and impacts of different groups are considered.

For example, the perspectives of mental health and addictions consumer survivors learned through the research initiative titled, 'Lemme tell you how it works': A consumer/survivor and user-led gap analysis of mental health and addiction services in the Toronto Central LHIN, will help shape how mental health and addictions services are planned and evaluated in 2011/12. The Health Equity Impact Assessment Tool that was rolled out to hospitals and other providers and used for Aging at Home and other LHIN-led initiatives starting in 2010/11 will be increasingly used for decision-making regarding service delivery.

The Aboriginal Diabetes Research project in the Toronto Central LHIN will provide critical missing information about diabetes in Toronto's Aboriginal Communities and culturally relevant approaches to preventing and managing diabetes among urban Aboriginals.

In 2011/12, the Toronto LHIN will engage with consumers, health service providers, health professionals and other community stakeholders to build on progress to date with a multi-year health equity strategy designed to ensure all people receive a high standard of care.

### Key 2011/2012 Activities

While we develop this strategy, the LHIN will focus on the following priority actions in the 2011/12:

- Developing a common data collection approach and data set starting with hospitals in 2011/12 to enhance the ability to understand and address inequities.

- Identify which equity indicators will be tracked and incorporated into the LHIN's scorecard and HSP accountability agreements in 2012-13.
- Advance opportunities to improve access to and quality of language and interpretation services, leveraging the proposed Improving Equity Through Language Access model developed by Sick Kids and other health service providers.

### **Spotlight on French Language Services**

The LHINs are subject to the French Language Services Act (FLSA) which requires us to provide “active offer” of French Language Services to the Francophones we serve. In addition, the Local Health Services Integration Act (LHSIA) sets out obligations for the LHIN to engage Francophones to inform health system priorities, actions and performance indicators. The just-announced French Language Services (FLS) planning entities will play a critical role in advising the LHINs regarding local FLS needs and priorities.

The FLS entity for the “zone” covering Toronto Central (TC), Central West and Mississauga Halton LHINs has now been announced and the three LHINs are working together to establish a relationship with the new entity and negotiate the inaugural accountability agreement. As the Lead LHIN, the TC LHIN will work closely with the other two LHINs to establish a strong collaboration with the FLS planning entity.

The Toronto Central LHIN has hired an FLS Coordinator to lead community engagement with the diverse Francophone communities living in or receiving care within the TC LHIN. The FLS Coordinator will provide strategic advice on FLS issues and contribute to the LHIN's planning, integration, community engagement and performance improvement work. The FLS coordinator is also a key liaison between the LHIN and the FLS planning entity.

The TC LHIN will undertake the following activities in 2011/12 to meet its accountabilities and to help address the health needs of the Francophone communities we serve:

- **Develop FLS strategy:** Review current Integrated Health Services Plan (IHSP) initiatives and recommend actions to ensure FLS are part of the planning, implementation and evaluation of each initiative.
- **Stakeholder relations:** Manage stakeholder relations with designated and non-designated HSPs, the Francophone community, the planning entity, other LHINs. As LHIN lead for the FLS entity, the TC LHIN will promote collaborative relationships with all stakeholders and advance best practices.
- **Francophone engagement:** Work closely with the FLS planning entity to enhance local Francophone engagement. The TC LHIN also plans to organize a discussion forum for members of the Francophone community (including Toronto Central, Central West and Mississauga Halton) on how to use an equity lens for engaging Francophone groups and for planning and decision-making.
- **Focus on addressing the needs and gaps of marginalized and newcomer Francophone populations.**
- **Commission a research paper to map current services, organizations, agencies, networks, committees, places of congregation for people who speak French, including newcomer communities that communicate in French but may not identify as Francophone to identify gaps and inform future planning and initiatives.**

## eHealth

In the TC LHIN, eHealth is a key enabler of the LHINs five priority areas and plays a lead role in harnessing information technology and innovation to improve patient care, safety and access. The eHealth landscape in the TC LHIN is an extremely complex environment, comprised of several large-scale, high investment solutions. As such, HSPs benefit from the coordination and direction provided by the LHIN and eHealth Ontario to create an integrated and effective eHealth environment.

To date, eHealth Ontario has supported the LHINs in the form of one-time funds to operate an eHealth Project Management Office model. These funds have allowed the LHINs to work directly with HSPs, other LHINs and eHealth Ontario to drive provincial and regional projects while leveraging the strength in understanding the unique features of each local environment. This support has been critical and instrumental in achieving the successes of many key note initiatives, including the TC LHIN's RM&R project, which has become one of the faster growing and most coordinated eHealth initiatives in Ontario.

### 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, and match people to the most appropriate level of care based on a standardized assessment of need(s). To date,
  - Inpatient medical and surgical units in six acute care facilities are using RM&R to refer patients to LTC homes, convalescent care, CCAC for in-home services, and rehabilitation and CCC hospitals
  - Eight rehabilitation and CCC facilities are receiving referrals from acute care, and sending referrals to LTC homes, convalescent care, and CCAC for in-home services;
  - TC CCAC is using RM&R to receive referrals for LTC home placement and in-home services;
  - 37 LTC homes using RM&R to receive referrals from the CCAC for placement.
  - A sub-set of CSS HSPs that provide services for seniors are preparing to implement RM&R to facilitate their referral processes. As part of this implementation, hospital in-patient units, ERs, the CCAC, and some CSS agencies will all be able to send referrals for these services via RM&R.
  - Implementation of LTC home bed-level matching in RM&R is almost complete and will allow the matching of clients to a specific bed within a LTC home. Through this implementation, referrals and waitlists for LTC are now facilitated through a single system.
- *ConnectingGTA (cGTA)* is a solution enabled by information technology that will allow Greater Toronto Area (GTA) HSPs 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. ConnectingGTA project has sponsored foundational initiatives that are helping to set the stage for the broader ConnectingGTA solution. In addition to testing key technology concepts for future use, these initiatives will provide 1,200+ clinicians with access to electronic patient health information. One of these initiatives, the LHIN Exchange Access Point (LEAP), is leveraging the initial success of the Patient Results Online (PRO) system;

new users will be able to electronically access clinical data outside of their LHIN and the experience for existing users at 30 participating organizations will be enhanced. Through LEAP, clinical information will be exchanged across four LHINs – Central, Mississauga-Halton and Toronto Central and North Simcoe Muskoka.

- *A Diagnostic Imaging Repository (DI-r)* is a collection of all patients' diagnostic imaging results in single, standards-based repository that will support sharing of images locally, regionally, provincially and on a pan-Canadian basis. The creation of a diagnostic imaging repository is a critical component of the interoperable electronic health record. The GTA West Diagnostic Imaging Repository (GTA West DI-r) will provide clinicians access to all patient images and reports acquired at any partner health care facility in the GTA West.
- *The Diabetes Registry* is a web-based, interactive, real-time application designed to support better management of diabetes care. Together with a Registry and Portal, the solution will compile information from provincial data sources to:
  - Enhance communication among the care team
  - Provide alerts and reminders to facilitate the provision of best practices
  - Provide reports and dashboards at various levels (province, LHIN, patient)
  - Incorporate Canadian Diabetes Association's Clinical Practice Guidelines to support patient care
  - Enable improved care delivery planning and support with aggregate level reports
- *The Community Care Information Management (CCIM) Integrated Assessment Record (IAR) Viewer* will enable care providers within the circle of care to access standard common assessment data in order to facilitate collaborative client care planning and delivery. This initiative builds on the foundational structure of the CCIM program which is responsible for developing a common assessment capability across the Community sector.

### **Key 2011/2012 Activity**

- Continue the expansion of the TC LHIN RM&R Program: RM&R implementation for community referrals including hospital in-patient units, ERs, the CCAC, and community agencies; improved reporting and analytics; and implementation planning for acute expansion beyond medical and surgical inpatient units.
- Continue to implement foundational projects (including LEAP) as well as procure a solution for the back-end technical ConnectingGTA infrastructure.
- Continue the build and configuration of the GTA West DI-r solution in preparation for implementations.
- Continue local planning for the implementation of the diabetes registry at the direction on eHealth Ontario.
- Local planning, engagement and implementation of the CCIM *IAR* Viewer for MHA agencies

### 3. LHIN Operations and Staffing Templates

Template B: LHIN Operations Spending Plan					
LHIN Operations (\$)	2009/10 Actuals	2010/11 Forecast	2011/12 Planned Expenses	2012/13 Outlook	2013/14 Outlook
<b>Operating Funding (excluding initiatives)</b>	<b>5,732,821</b>	<b>5,818,921</b>	<b>6,770,828</b>	<b>7,196,933</b>	<b>7,027,097</b>
<b>Salaries and Wages</b>	4,050,969	3,612,814	4,122,326	4,317,326	4,567,326
<b>Employee Benefits</b>					
HOOPP	379,969	81,755	453,456	226,410	226,410
Other Benefits		661,471	535,902	730,489	730,489
<b>Total Employee Benefits</b>	<b>379,969</b>	<b>743,226</b>	<b>989,358</b>	<b>956,899</b>	<b>956,899</b>
<b>Transportation and Communication</b>					
Staff Travel		33,500	33,500	34,500	35,000
Others	108,080	184,970	184,970	210,089	214,291
<b>Total Transportation and Communication</b>	<b>108,080</b>	<b>218,470</b>	<b>218,470</b>	<b>244,589</b>	<b>249,291</b>
<b>Services</b>					
Accommodation	265,333	323,149	391,470	405,899	426,193
Consulting Fees	72,522	250,628	75,000	75,000	75,000
Governance Per Diems	100,550	100,550	165,000	165,000	165,000
LSSO Shared Costs	375,000	410,000	410,000	410,000	410,000
Other Governance Costs	4,004	7,880	-	-	-
Other Services	272,823				
<b>Total Services</b>	<b>1,090,232</b>	<b>1,092,207</b>	<b>1,041,470</b>	<b>1,055,899</b>	<b>1,076,193</b>
<b>Supplies and Equipment</b>					
IT Equipment					
Office Supplies & Purchased Equipment	102,557	152,204	174,204	172,220	177,387
Other S & E					
<b>Total Supplies and Equipment</b>	<b>102,557</b>	<b>152,204</b>	<b>174,204</b>	<b>172,220</b>	<b>177,387</b>
Capital Expenditures			225,000	450,000	
<b>LHIN Operations: Total Planned Expense</b>	<b>5,731,807</b>	<b>5,818,921</b>	<b>6,770,828</b>	<b>7,196,933</b>	<b>7,027,097</b>
<b>Variance</b>	<b>1,014</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>

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

<b>Position Title</b>	<b>2009/10</b>	<b>2010/11 Forecast FTEs</b>	<b>2011/12 Plan FTEs</b>	<b>2012/13 Outlook FTEs</b>	<b>2013/14 Outlook FTEs</b>
CEO	1	1	1	1	1
Senior Director	2	2	2	2	2
Controller	1				
Executive Assistant	2	2	2	2	2
Administrative Assistant	2	2	2	2	2
Receptionist	1	1	1	1	1
Community Eng Consultant	1	1	1	1	1
Planner	1	1	1	2	2
Funding & Allocation Consultant	1	1	1	1	1
Sr Perf/Cont/Alloc Consultant	4	4	4	4	5
Business Manager	1	1	1	1	1
Director	2	3	3	3	3
Financial Coordinator	1	1	1	1	1
Financial Analyst	3	3	3	4	4
Program Dev Consultant	2	2	2	2	2
Sr Planner	1	1	1	1	1
Sr. Integration Consultant	4	4	4	4	5
Perf Measurement Analyst	2	2	3	4	4
Sr. Perf Meas Analyst	1	1	2	1	1
Sr. Community Engagement Consultant	1	1	1	1	1
Community Eng Coordinator	2	2	2	2	2
Sr. Health Design Consultant	1	1	1	1	1
Health Design Consultant	1	1	1	1	1
French Language Services Coordinator	0	0	1	1	1
<b>Total FTEs</b>	<b>38</b>	<b>38</b>	<b>41</b>	<b>43</b>	<b>45</b>

## 4. Communications Plan

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<b>Objectives:</b>
<ul style="list-style-type: none"><li>• Inform HSPs, community and other stakeholders in the TC LHIN about ABP.</li><li>• Promote understanding of, support for and involvement in the implementation of the priority initiatives in the ABP.</li></ul>
<b>Context:</b>
<p>LHINs develop ABPs to clearly articulate measurable goals for the coming year and to formulate plans to achieve those goals. The ABP also helps the LHIN ensure that our goals and objectives are aligned with the priorities set out in the 2010-2013 IHSP and brings about focus and clarity of what is to be achieved in the coming year.</p> <p>Communications and engagement with key audiences about the ABP helps to build awareness, understanding and support for the TC LHIN's goals and its associated initiatives.</p>
<b>Target Audience:</b>
<b>Primary</b> <ul style="list-style-type: none"><li>• MOHLTC TC LHIN-funded HSPs</li><li>• TC 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.</li></ul> <b>Secondary</b> <ul style="list-style-type: none"><li>• Community groups in TC LHIN</li><li>• General public in TC LHIN</li><li>• Patients and families who receive care in the TC LHIN</li><li>• Other health care stakeholder groups</li></ul>
<b>Strategic Approach:</b>
<p>The TC LHIN will take a targeted approach to communications regarding the ABP, using engagement to involve and inform community stakeholders and HSPs.</p> <p>TC LHIN will take a low-profile approach to communications with the general public regarding the ABP as MOHLTC approval to publicly post the ABP is typically received late in the year. Once approval for public release is received from the MOHLTC, the TC LHIN will post the document on its web site.</p>

**Key Messages:**

- The ABP sets out specific actions for improving health care services in the TC LHIN in 2011/12.
- This plan involves all the HSPs 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 2011/12, more people in the TC 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.

**Tactics:**

<i>Audiences</i>	<i>Tactics</i>	<i>Issues and Opportunities</i>
MOHLTC	<ul style="list-style-type: none"> <li>• Submit report and post on web site once approved.</li> </ul>	
TC LHIN-funded HSPs	<ul style="list-style-type: none"> <li>• Review ideas in the ABP, and provide opportunities for feedback and dialogue through engagement sessions – i.e., HSP Leadership Forum.</li> <li>• Issue communiqué from CEO to announce final MOHLTC-approved ABP; newsletter article; post on web site.</li> <li>• Post-release presentations at HSP Leadership Forum, sector tables, and CEO and senior management HSP presentations and meetings.</li> </ul>	<ul style="list-style-type: none"> <li>• HSPs have a high level of support for TC LHIN’s priorities as well as health equity and e-health enablers.</li> <li>• Some sector-specific concerns about change readiness and change management capacity.</li> <li>• Some initiatives may require HSPs and sectors to collaborate in new ways and agree to change the way they deliver services for the good of the system and the individuals they serve.</li> </ul>
TC LHIN community engagement and	<ul style="list-style-type: none"> <li>• Review ideas in the ABP and work on implementation processes</li> </ul>	<ul style="list-style-type: none"> <li>• Have a high level of support for TC LHIN’s priorities as well as health equity and e-health enablers.</li> </ul>

advisory groups.	<p>during winter 2011.</p> <ul style="list-style-type: none"> <li>• Issue communiqué from CEO to announce final MOHLTC-approved ABP; newsletter article; post on web site.</li> </ul>	<ul style="list-style-type: none"> <li>• Some sector-specific concerns about change readiness and change management capacity.</li> <li>• Consumer Panels (MHA, 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.</li> </ul>
General public	<ul style="list-style-type: none"> <li>• Newsletter article; post on web site.</li> </ul>	<ul style="list-style-type: none"> <li>• Some may question the reason behind the late date of the public posting of the ABP.</li> </ul>

# LSSO 2011/12 ABP Submission

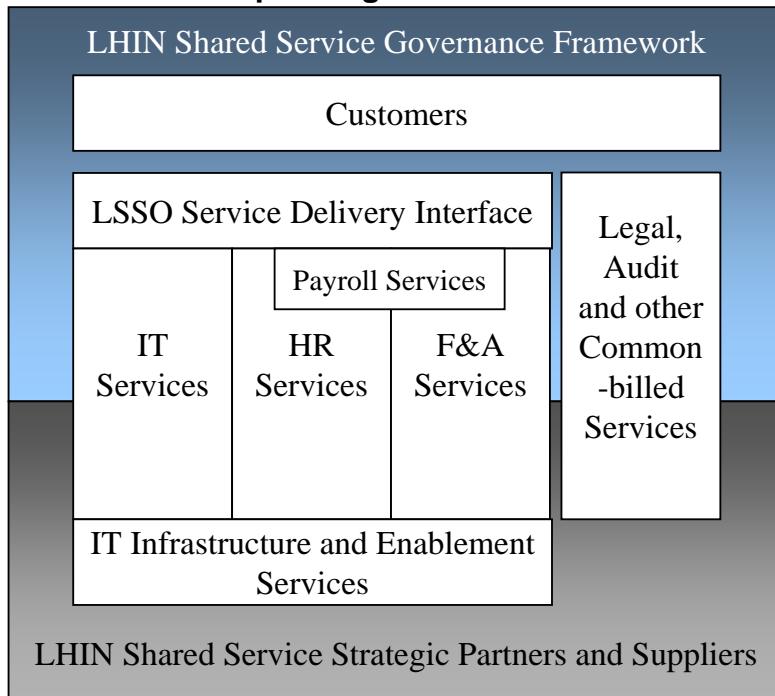
## Introduction and Current Mandate

The LHIN Shared Service Office (LSSO) is a division of the TC LHIN but is funded equally by all 14 LHINs. It is responsible for providing the Information Technology (IT) and IT enabled services as well as Human Resources (HR), Payroll and Finance & Accounting for the LHINs. The LHIN Legal Services Branch (LLSB) provides legal services to all LHINs through funding included as part of the overall LSSO budget, but the delivery of LLSB services is managed separately from the LSSO.

The LHINs renewed their Shared Services Agreement with LSSO in April 2009. This agreement defines the arrangements between the 14 LHINs for sharing the services provided by the LSSO.

The LSSO Strategic Plan covering the period 2008/09 to 2010/11, created with the assistance of Stevenson Kellogg, included the following Shared Services Operating Model:

**Figure 1.0 LHIN Shared Services Operating Model**



A new governance review of the LSSO is currently being undertaken by TC LHIN and the results will not be available until after this ABP document is finalized. Therefore, they are not reflected in this ABP submission.

The Shared Service Operating Model consists of 11 components which are briefly described below. LSSO has described over 30 specific services that are delivered to the LHINs, either as mandatory or optional services. Additional initiatives are summarized in the Environmental Scan section of this report, identified by the service and benefit they provide to the LHINs. These initiatives are further described in more detail in a separate document which is appended as *LSSO Projects and Initiatives Identified for the 2011-12 ABP Planning Cycle*.

1. LHIN Shared Service Governance Framework is the set of policies, procedures and agreements that provide direction to the LSSO operations so that projects and services are aligned with the expectations of the LSSO customers. The concept of shared services was a condition of establishing the LHINs and is described in the Shared Services Agreement as follows: “Cabinet directed the Ministry to ensure that common services were delivered efficiently and cost effectively to the LHINs.”

In practice, the LSSO management committee establishes direction for LSSO operations to be overseen by the LSSO Executive Director. The committee provides oversight on behalf of the 14 LHIN CEOs and Board Chairs. The Shared Services Agreement (April 2009) defines how the LSSO will plan and operate. The agreement establishes the principle that LSSO costs will be “paid by all parties on an equal basis.”

2. Customers are the 14 LHINs and their staff. Individual customers such as senior directors or office managers are within this group.
3. LSSO Service Delivery Interface is the point of contact between the LSSO operations and the LHINs. The interface has many aspects:
  - a) Define services, monitor and report service delivery levels
  - b) Fix, maintain and improve existing services
  - c) Prioritize and create new project and new service introductions
  - d) Advise on related service improvements

The following six components are the currently defined LSSO services delivered to the LHINs. These services have been recognized as necessary for the efficient and cost effective operation of the LHINs and are referred to as common services.

1. IT and Related Services which includes local desktop and printer service, mobile services (laptops and blackberries), email and network services, office telephone and electronic document services.
2. Human Resources Services includes advice and support on all human resources-related matters such as compensation, hiring, promotion, termination, benefits and payroll and organizational development.
3. Finance & Accounting Services include the capture, processing and recording of financial transactions. The main processes here include the accounts payable and general ledger system and support for these processes for the 14 LHINs.
4. Procurement Advisory Services include the monitoring of Ministry of Government Service’s vendor of record arrangements for changes and updates, advising the LHINs on procurement matters including provision of standard templates for use by all 14 LHINs, proactively addressing new and emerging procurement requirements as legislated or directed by the government of Ontario.
5. Payroll Services includes the regular processing of payroll for all LHIN staff, in accordance with LHIN compensation policies and appropriate government payroll regulations.
6. Legal, Audit and Other Common-Billed services include advisory and procurement related services provided by the LSSO in-house legal staff, and audit coordination services provided to the LHINs. These services are not necessarily enabled by IT. These services are included in the single charge to the LHINs as defined in the Shared Services Agreement, and are referred to as common-billed services.

The following two components are related to LSSO two key suppliers: CGI and eHealth Ontario Agency (formerly known as Smart Systems for Health).

1. IT Infrastructure and Enablement Services includes supporting infrastructure services such as province-wide voice and data network, and Toronto based computer centre operations. This service also includes the central help desk and problem management process. This service is a combined responsibility of LSSO, (CGI currently) and eHealth Ontario.
2. LSSO Strategic Partners and Suppliers includes relationship and contract management between LSSO and suppliers. In addition, several smaller vendors provide services such as office equipment and supplies, phone services, consulting and audit services, etc.

## **Environmental Scan of Opportunities and Risks**

### **Technology Infrastructure Initiatives**

In consultation with the LHIN stakeholders the LSSO has identified the following technology initiatives as priority projects within the budget period included in the ABP Template B Operations Spending Plan. Delivery details, budgets and tasks are identified in the Project Initiatives document, attached.

- Document management tools and strategy including electronic storage, sharing, and retrieval of documents (SharePoint)
- Enhanced inter/intra LHIN communication capability (SharePoint)
- Customer relationship management and campaign management tools (CRM)
- Standard practices and templates for project management across the LHINs and within the LSSO (PMO)
- Enhanced reporting capability for on-line HSP reporting and information gathering (Performance Module for SharePoint)
- Faster and more robust back office technology to support the above requirements (Office 2007 Upgrade)

### **Human Resource Programs and Initiatives**

In consultation with the LHIN stakeholders, including CEOs, Controllers, Business Managers and other management and staff, a number of gaps have been identified in the human capital support and management toolkit for the LHINs. The LSSO has formed a working group with a mandate to roll out a number of new initiatives to support management and staff in the LHINS. The following initiatives have been identified as priority projects within the budget period included in the ABP Template B Operations Spending Plan. Delivery details, budgets and tasks are identified in the Project Initiatives document, attached.

- Gauge the level of employee satisfaction and concerns as a baseline for future employee initiatives and as a baseline for key performance indicators which can be measured and tracked on a dashboard for all LHINs and the LSSO (Employee Survey early 2011).

- Gauge the level of employee satisfaction and concerns after rolling out multiple initiatives (Employee Survey early 2012).
- Provide documented fair and equitable job descriptions and compensation programs for enhanced resource management and employee satisfaction, improved morale and reduced employee turnover and associated costs (Job Evaluation and Compensation Design).
- Ensure legislative requirements are followed to protect employees and reduce health and safety related risks and audit risks at the LHINs (Health and Safety Program).
- Provide a robust and up-to-date employee policy handbook to ensure consistent and fair treatment of employees across all LHINs while still allowing room for LHIN specific differences. Expected benefits include improved employee morale and motivation (HR Policy Rebuild).
- Enhance the new employee 'experience' and on-boarding process to ensure new staff are able to 'hit the ground running' and contribute to LHIN core business activities quickly (Orientation Program).
- Provide a tool for the LHINs to ensure consistent methodologies for linking staff performance objectives with key LHIN objectives, and then consistently measure staff against their performance objectives for improved resource management and performance results (Performance Management System).
- Provide a tool for the LHINs to better motivate and reward staff resulting in improved resource management, employee satisfaction, and employee retention (Rewards and Recognition Program).

## **Finance and Corporate Services Programs and Initiatives**

In consultation with the LHIN stakeholders, including CEOs and the LSSO Management Committee, several areas for improved services have been identified. These items address areas for improvement identified during audits and internal process reviews. The following initiatives have been identified as priority initiatives within the budget period included in the ABP Template B Operations Spending Plan. Delivery details, budgets and tasks are identified in the Project Initiatives document, attached.

- Provide training, support and tools to help the LHINs better understand, implement, and meet procurement guidelines and legislative requirements as well as reduce compliance risk (Procurement System Development).
- Facilitate improved tracking of spending from initial request through to payment which allows seamless contract reporting to reduce time spent on these administrative tasks and allow LHINs to focus on core activities (Financial/Procurement Systems Rebuilt Across LHINs – Phase II).
- Work with the LHINs to facilitate a risk management framework to address requirements for risk mitigation across the LHINs (Enterprise Risk Management).

## **Current Status**

The current operating budget of the LSSO (through the LHINs) is insufficient to build the infrastructure beyond the current state, and the identified projects and initiatives above.

- LSSO costs increase as LHIN staff numbers increase because the number and variety of support requirements increase. As new technologies and software tools are implemented to support the LHINs there are increased operating costs for support and maintenance, including licenses and vendor support agreements. As desktop/laptop and infrastructure hardware age they must be renewed, and there is no room in the LSSO budget to build in a hardware refresh program for infrastructure. This results in reduced infrastructure performance against demands, and increased risk of key equipment failures.
- The LSSO has the opportunity to be a strategic business partner with the LHINs and deliver services that enhance the ability of the LHINs to deliver on their mandates. It was the vision of the LSSO to establish itself as a high quality deliverer of strategic business solutions and back office support. We recognize the importance of maintaining a 'value for money' approach to operating and will continue to drive for efficiencies in all that we undertake.
- Within the LHIN business model, the management preferences of the LHIN CEOs directly influence the resource requirements at each LHIN and the subsequent direction that the LHIN takes. These varying LHIN preferences have a profound effect on the ability of the LSSO to meet the needs of all of the LHINs – specifically when constrained by a vendor contract for IT infrastructure, financial system and payroll system services (CGI) which represents over forty (41%) per cent of the LSSO budget, and up to sixty per cent (60%) of the current LSSO service offering.

## **Current Opportunity – Renew, Rebuild, Refresh**

With the expiration of the major vendor (CGI) contract in March 2011, the LSSO will be extending the contract for a period of time to enable the transition of those vendor-provided services to a new LSSO service model as part of LSSO's transition to a LHIN strategic business partner.

As identified in Template B of the ABP documentation, the LSSO will be requesting an advance of funding from the MOHLTC (through the LHINS) for the beginning of the 2011-12. The upfront funding is required to procure services, equipment and infrastructure to implement the solutions starting 'out of the gate' in April 2011 with a completion date prior to the end of March 2012. The upfront funding required (additional funding required over and above any other funding provided to the LHINS in 2011-12) is quantified as \$3,053K (just over \$3 million dollars).

This project includes the funding to replace the aging and outdated IT infrastructure equipment and improve infrastructure and network performance across the LHINs.

This funding will be repaid (by the LSSO) through the LHINs to the MOHLTC out of the anticipated annual operating cost savings of approximately \$1 M as a result of implementing the identified solutions. A detailed business case and documentation has been provided to the LHIN Liaison Branch and the MOHLTC Procurement Advisory Services Group. Once funding has been confirmed and the additional appropriate documentation is completed, the LSSO anticipates this will be presented to the Supply Chain Leadership Council early in calendar 2011 for approval.

Because these funds and the spending have not yet been approved by Supply Chain Leadership Council, the financial, staffing and operating impacts of this project are not reflected in any of the documentation provided as part of this ABP cycle.

## **Detailed Plans for the LSSO**

While a significant portion of the efforts and the funding of the LSSO are geared towards implementing, supporting and growing the IT infrastructure, the other areas of our service offering are also examined each year for efficiency gains, and ensuring that they continue to meet the business needs of the LHINs. Many of the initiatives identified above are in direct response to LHIN business needs in the non-IT areas of service provided by the LSSO.

A significant portion of the day-to-day activities of the LSSO are involved in supporting the LHINs as they deal with issues that arise in their business. HR advice and support is given to each LHIN as requested. Similarly financial advice is given to LHINs as they deal with financial, payroll, procurement and other operating issues. As much as possible the LSSO strives to be proactive in the project and support work that is undertaken. However, if the LHINs communicate to the LSSO that they have a new business need that requires back office support or tools then the LSSO resources must be redirected to providing support to that new initiative or new resources must be added to the LSSO.

# Financial Summary

Template B: LSSO Operations Spending Plan					
LHIN Operations Sub-Category (\$)	2009/10 Actuals	2010/11 Allocation	2010/11 Planned Expenses	2011/12 Planned Expenses	2012/13 Planned Expenses
<b>Salaries and Wages</b>	<b>1,162,395</b>	<b>1,474,180</b>	<b>1,664,103</b>	<b>1,923,731</b>	<b>1,952,587</b>
<b>Employee Benefits</b>					
HOOPP	59,144	123,784	89,322	123,624	125,478
Other Benefits	88,305	86,391	133,186	96,918	98,371
<b>Total Employee Benefits</b>	<b>147,449</b>	<b>210,175</b>	<b>222,508</b>	<b>220,542</b>	<b>223,850</b>
<b>Transportation and Communication</b>					
Staff Travel	16,698	30,154	20,715	22,814	23,156
Governance Travel	-	-	-	-	-
Communications	75,578	31,614	70,146	49,393	50,133
Other Benefits	6,014	-	10,111	10,358	10,513
<b>Total Transportation and Communication</b>	<b>98,289</b>	<b>61,768</b>	<b>100,972</b>	<b>82,564</b>	<b>83,803</b>
<b>Services</b>					
Accommodation	111,353	172,040	163,954	132,110	134,092
Advertising	-	-	-	-	-
Banking	3,944	500	12,043	500	508
Community Engagement	-	-	-	-	-
Consulting Fees	290,139	153,800	49,543	26,540	26,938
Equipment Rentals	3,994	5,040	5,026	5,400	5,481
Governance Per Diems	-	-	-	-	-
LSSO IT Contracted Services	1,860,609	2,299,665	2,045,705	2,082,761	2,114,003
Other Meeting Expenses	636	5,897	4,912	3,425	3,476
Other Governance Costs	-	-	-	-	-
Printing & Translation	1,970	1,025	449	1,025	1,040
Staff Development	5,268	30,426	20,068	27,100	27,507
<b>Total Services</b>	<b>2,277,913</b>	<b>2,668,393</b>	<b>2,301,699</b>	<b>2,278,862</b>	<b>2,313,044</b>
<b>Supplies and Equipment</b>					
IT Equipment and Software	718,316	179,419	182,477	167,547	170,061
Office Supplies & Purchased Equipment	34,534	38,989	32,756	35,587	36,121
<b>Total Supplies and Equipment</b>	<b>752,849</b>	<b>218,408</b>	<b>215,233</b>	<b>203,135</b>	<b>206,182</b>
<b>Projects in Support of LHINS - TBD</b>	<b>1,039,293</b>	<b>400,000</b>	<b>528,408</b>	<b>399,585</b>	<b>405,578</b>
<b>LSSO Operations: Total Planned Expense</b>	<b>5,478,189</b>	<b>5,032,924</b>	<b>5,032,924</b>	<b>5,108,418</b>	<b>5,185,044</b>
<b>Annual Funding Target - To be funded by the LHINS</b>			<b>4,787,601</b>	<b>5,032,924</b>	<b>5,108,418</b>
<b>Variance</b>			<b>245,323</b>	<b>75,494</b>	<b>76,626</b>
% Increase to be funded by LHINS			5.1%	1.5%	1.5%

## ADDITIONAL FUNDING REQUIREMENTS

Renew, Rebuild, Refresh Project Funding requirements, currently under review by MOHLTC for short term one-time funding of the project. Pending approval. Assumes it will be repaid to the MOHLTC in annual increments from 2012-13 through 2014-15					\$ 3,053,791
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## Staffing Plan

Position Title	2010/11 Actual FTEs as of Mar. 31/10	2010/11 Forecast FTEs	2011/12 Forecast FTEs	2012/13 Forecast FTEs
Executive Director	1	1	1	1
Controller	1	1	1	1
HR Manager	1	1	1	1
IT/PMO Manager	1	1	1	1
LSSO Operations Support	1		1	1
Payroll Specialist	1	1	1	1
Executive Coordinator, LLC	1	1	1	1
Procurement Specialist	1	1	1	1
IS Lead	1	1	1	1
Project Manager	1	1	1	1
Project Coordinator	1	1	1	1
CRM/SharePoint Configuration Specialist		1	1	2
Business Analyst (new)		1 (a)	1	2
IT Infrastructure Specialist		1 (a)	1	1
HR Administrator			1	1
Financial Analyst		1	1	1
Executive Assistant - Legal	1	1	1	1
Executive Assistant LSSO/LHINC	0.5	0.5	1 (LSSO only)	1
Total FTEs	12.5	15.5	18	20

(a) Project

## **2011-12 Budget and 1 year forecast assumptions**

The following assumptions were considered when compiling the budget and 1 year forecast:

- The maximum additional funding that may be available from the LHINs would be 1.5% per year.
- Additional staff will be hired within the budget and forecast amounts provided.
- The budget and 1 year forecast are inclusive of costs for the Legal Services Branch
- A 1.5% average performance amount was budgeted for permanent FTEs only.
- Staff benefit costs would be budgeted at 22% of salaries for permanent FTEs.
- Funds available for any additional and unidentified projects will be those available after all other costs have been met.
- The LSSO IT contracted services amount reflects the costs associated with continuing the existing type of service contracts currently place and does not reflect the impact of implementing the Renew, Rebuild, Refresh project.
- The one-time costs of the Renew, Rebuild, Refresh project are identified as a separate line item only in 2011-12. The ongoing cost impacts are not reflected in future years for this ABP document.

### **Budget commentary**

The significant points of note about the budget and forecast are:

- The LSSO budget for 2010-11 was created in conjunction with discussions with LHIN staff and other stakeholders.
- The LSSO budget for 2011-12 was based on current operating costs discussions with LHIN stakeholders for approved projects and initiatives
- Any projects not funded within this budget and forecast document have not been identified as priority projects or initiatives
- Any staffing required for future projects or initiatives not included in this document would be funded through project funding from the LHINs as those projects are requested and approved
- Project funding identified in this document is significantly less than required to meet proposed project requests from the LHINs. The demand continues to far exceed the available funding and the staff resource complement within the LSSO.

### ***Budget Analysis – 2011-12***

#### ***Staffing Costs***

#### ***\$2.2 M or 43% of total budget***

- Shared Services Staff 18 FTEs – Executive Director, Executive Assistant, Controller, Manager HR, IT/PMO Manager, Payroll and Benefits Specialist, Operations Support, Executive Coordinator, Procurement Specialist, IS Lead, Project Manager, Project Coordinator, Business Analyst, IT

Infrastructure Specialist, SharePoint Configuration Specialist, HR Administrator, Financial Analyst, Executive Assistant Legal Services Branch.

- As projects are implemented and services expanded staff must be hired to provide ongoing support, resulting in a increase of 2.5 FTE's for 2011-12 over 2010-11
- A 1.5% average performance amount was budgeted for permanent FTEs only
- Benefits budgeted at 22% of base salary for permanent staff, 10% of base salary for contract staff.
- Other staff costs such as training, blackberry, travel etc are consistent with those of 2010-11

### ***IT Contracted Services Costs***

***\$2.1 M or 41% of total budget***

- Represents three vendor contracts: CGI for back office services, GSI for LHIN external website support, and Primus for backup and storage of external website content.
- Year-over-year increase reflects increase in LHIN demand slightly offset by retirement of surplus equipment and deactivation of unused active directory user accounts late in 2010-11
- Significant savings are anticipated in this budget line once the Renew, Rebuild, Refresh project has been fully implemented (2012-13). As stated earlier these savings are not reflected in the budget because the project has not yet been approved by Supply Chain Leadership Council.

### ***Project Costs***

***\$400 K or 8% of total budget***

- Specific projects are identified above in the section "Environmental Scan" as well as in the detailed supplementary document Entitled "LSSO Projects and Initiatives Identified for the 2011-12 ABP Planning Cycle".

### ***Supplies and Equipment***

***\$203 K or 4% of total budget***

- Includes hardware maintenance and software maintenance renewal costs and annual software license costs where required. Costs are lower than prior years because of the anticipated impact making changes associated with the IT Infrastructure Review early in 2011-12.
- Office supplies and purchased equipment costs are consistent with previous years

### ***Accommodation and Other Misc Services***

***\$169 K or 3% of total budget***

- Rent and other accommodation costs reflect both the Legal and Shared Services costs.
- Accommodation costs for an additional lawyer are included in the total.
- Audit costs are consistent with previous years

# LSSO Projects and Initiatives Identified for the 2011-12 ABP Planning Cycle

## LSSO Initiatives - Executive Summary

The LSSO is responsible for providing back office support to the LHINs for IT infrastructure, IT help desk, delivery of pan-LHIN IT projects, solutions and initiatives, HR leadership and organizational development guidance, payroll services, benefit program support, financial systems provision and support, financial leadership on pan-LHIN operational finance topics, procurement expertise support and guidance. Legal services are provided to the LHINs through the Legal Services Branch.

Over the past year the LSSO has worked with the LHINs to review the current and future strategy for the LSSO within the context of back office service delivery and support. Based on these discussions with the LHINs as well as with ongoing working groups with LHIN and LSSO participants, the key initiatives have been identified and included in this report. Where budget requirements have been identified and included in the 2011-12 ABP they are indicated in the budget column within this report. Where there are budget pressures and there is currently no funding within the LSSO budget, the estimated budget pressure has been identified in the key tasks area of this report.

The deliverables identified in this plan are pan-LHIN in nature and will deliver business solutions to the LHINs over the next two fiscal years. As the LHINs complete their Annual Operating Plans, it is expected that they will identify other projects that will require the LSSO to prioritize for delivery. This is an ongoing process and is part of the nature of this shared services organization.

There is one additional project that is not identified on this document. The Renew, Rebuild, Refresh project, when approved, will replace the current service provider for our back office IT infrastructure and support, payroll system, and financial systems with new and more robust tools and methods for providing the necessary back office solutions to the LHINs. This project is expected to be presented to the Supply Chain Leadership Council early in calendar year 2011. It will require up front funding from the MOHLTC in the amount of \$3,053 at the start of the 2011-12 fiscal year, and will be repaid from identified cost savings in 2012-13, 2013-14 and 2014-15. This is identified on Template B of the ABP documentation for LSSO.

The LSSO initiatives identified in this document fall within 3 categories: IT/PMO, HR, and Corporate Services.

### IT/PMO initiatives include:


- SharePoint Implementation
- CRM Implementation
- PMO
- Performance Module for SharePoint
- Office 2007 Upgrade






HR initiatives include:






- Employee Survey
- Benefits Program
- Job Evaluation and Design
- Health and Safety Program
- HR Policy Rebuild
- Orientation Program
- Performance Management System
- Rewards and Recognition Program






Corporate Services initiatives include:

- Financial/Procurement Systems Rebuild Across LHINS – Phase II
- Procurement Systems Development
- Enterprise Risk Management

PROJECT	Key Tasks	RESPONSIBILITY	Due Date	Status	Budget
<b>SharePoint Implementation</b> (in progress)	<p><b>Phase I</b></p> <ul style="list-style-type: none"> <li>• Launch SharePoint portal at 12 LHINs by March 31, 2010</li> <li>• Complete all Phase I components by September 2011</li> <li>• Implement a business solutions portal that will provide strategic support to LHIN employees</li> <li>• Provide a LHIN wide document management system</li> <li>• Provide a LHIN wide communications and collaboration portal</li> <li>• Build a project team utilizing operations team members for PAN LHIN implementation</li> <li>• Support the LHIN project teams on the implementation of operating practices</li> <li>• Engage employees in the development of revised operating practices and change management support</li> <li>• Train LHIN employees on revised operating practices</li> <li>• Update intranet tool with revised practices and learning materials</li> </ul> <p><b>Phase II – Future years</b></p> <ul style="list-style-type: none"> <li>• Cost to upgrade to SharePoint 2010 is estimated at \$140,000. The 2011-12 LSSO allocation is not sufficient to support this cost therefore it will not be implemented until additional funding is available.</li> </ul> <p><b>Key Project Elements:</b></p> <ul style="list-style-type: none"> <li>• Functional Specification – Identify specific LHIN and associated parties gains from this project</li> <li>• Technical Specification –Determine how the SharePoint application will integrate with existing applications</li> <li>• Operational Strategy – Develop roles and responsibilities for each individual who will be involved in the solution - day to day operations map</li> <li>• Governance – Document current state and future state - controls &amp; guidance necessary to get the optimal ROI from this investment</li> <li>• Strategy &amp; Execution - Phases and releases, total roadmap, in a KISS (Keep It Simple) format</li> <li>• Audit – Identify what is in place and its current state, audit on systems, licenses, infrastructure, SLA's, recommendations for best practice.</li> <li>• Plan - Detail project plan and resource needs with justifications</li> </ul>	PMO Richard Smith	September 2011		\$20,000

<b>CRM Implementation</b> (required)	<ul style="list-style-type: none"> <li>Engage LHIN employees in the development and rollout of current CRM system</li> <li>Launch CRM solution at remaining 12 LHIN locations by November 30, 2011</li> <li>Train defined employees on use of new system etc.</li> </ul>	PMO Richard Smith	February 28, 2012		\$227,000
<b>PMO</b> (recommended)	<ul style="list-style-type: none"> <li>Implement an enterprise-wide strategy for the standardized use of project management principles</li> <li>Implement a PMO portal in SharePoint</li> <li>Engage LHIN PMO staff in the development of tools and project management best practices</li> </ul>	ED/PMO	September 30, 2011		N/A
<b>Performance Module for SharePoint</b> (was in progress, currently on hold)	<ul style="list-style-type: none"> <li>Meet with current LHIN users of Performance Point</li> <li>Define user needs and optimal vision for Performance Point</li> <li>Have determined it requires implementation of SharePoint 2010 for LHIN desired functionality</li> <li>Work with vendors to define business requirements</li> <li>Develop Performance point solution</li> <li>Implement Performance Point at Three LHIN locations</li> </ul>	PMO Richard Smith	TBD		\$17,000
<b>Employee Survey</b> (recommended)	<ul style="list-style-type: none"> <li>Develop an enterprise-wide employee survey</li> <li>Ensure that CEOs approve the rationale and content</li> <li>Conduct an employee survey to gauge employee concerns and to build rationale for HR strategy across the LHINs</li> <li>Provide feedback to the Boards, CEOs and Staff</li> <li>Build Rationale for HR Strategy and build the impetus for change within the LHINs</li> </ul>	HR Paula Rankin	May 31, 2011 (start date may be accelerated) and May 31, 2012		\$7,000
<b>Financial/Procurement Systems Rebuild Across LHINs - Phase II</b> (required)	<ul style="list-style-type: none"> <li>Improve internal controls to manage spending and improve financial accountability</li> <li>Implement a seamless automated financial tracking system – from purchase order, contract management to payment of invoices – to be used for internal purposes.</li> </ul>	Finance and Procurement Shelley Dagorne	December 2011		N/A Included in Renew Rebuild Refresh Project

PROJECT	KEY TASKS	RESPONSIBILITY	DUE DATE	STATUS	BUDGET
<b>Procurement System Development</b> (in progress)	<ul style="list-style-type: none"> <li>• Work with Controller's Committee to process map a practical procurement system for implementation in the LHINs. Working group ongoing.</li> <li>• Launch redesigned procurement system through SharePoint to the LHINs</li> </ul>	Procurement Rosanna Arduini	January 31, 2011		N/A
<b>Benefits Program</b> (in progress)	<ul style="list-style-type: none"> <li>• Define vision for LHIN benefits offerings</li> <li>• Prepare RFP for consultant – go to market – hire benefits consultant</li> <li>• Work with successful consultant to prepare RFP for benefits provider</li> <li>• Go to market – hire provider</li> <li>• Implement benefits best practices</li> </ul>	HR Paula Rankin	April 1, 2011		\$50,000
<b>Job Evaluation and Compensation Design</b> (recommended)	<ul style="list-style-type: none"> <li>• Implement a job evaluation system for 14 LHINs in line with approved guidelines and HR best practices</li> <li>• Update job descriptions and complete job evaluation for each – develop and implement supporting policies and procedures</li> <li>• Develop competitive new pay bands for all LHIN personnel</li> <li>• Provide retro payments to applicable staff</li> </ul>	HR Paula Rankin	March 31, 2012		\$30,000
<b>Health and Safety Program</b> (in progress)	<ul style="list-style-type: none"> <li>• Develop and implement a health and safety program for all LHINs – that meets legislative requirements</li> <li>• Train new JHSC members</li> <li>• Introduce policy framework to support the program</li> </ul>	HR Paula Rankin	March 31, 2011		N/A
<b>HR Policy Rebuild</b> (in progress)	<ul style="list-style-type: none"> <li>• Revamp all existing policies and procedures</li> <li>• Create a manager's tool kit of policies and HR best practices</li> <li>• Implement revised policies through SharePoint</li> <li>• Provide training and support to the LHINs during implementation</li> </ul>	HR Paula Rankin	March 31, 2011		N/A

PROJECT	KEY TASKS	RESPONSIBILITY	DUE DATE	STATUS	BUDGET
<b>Enterprise Risk Management</b> (sample)	<ul style="list-style-type: none"> <li>Develop a framework for ERM</li> <li>Complete internal survey to gauge current state assessment</li> <li>Develop and implement a comprehensive ERM program designed to mitigate risk</li> </ul>	Finance Shelley Dagherne	July 31, 2011		N/A
<b>Orientation Program</b> (recommended)	<ul style="list-style-type: none"> <li>Develop and implement a standardized orientation program that meets the needs of the LHINs including learning materials, manuals etc.</li> <li>Upgrade SharePoint with revised materials where required</li> </ul>	HR Paula Rankin	June 30, 2012		N/A
<b>Office 2010 Upgrade</b> (recommended)	<ul style="list-style-type: none"> <li>Upgrade Microsoft Office 2007 to MS Office 2010 at all LHIN locations</li> <li>Provide change management support and training to LHINs</li> <li>Implement Office 2010 with SharePoint ,CRM and Performance Point</li> <li>Cost to upgrade to Office 2010 is estimated at \$360,000</li> <li>Funding is not available in the 2011-12 budget</li> <li>This is an in-year budget pressure for 2011-12</li> </ul>	IT Richard Smith	June 30, 2012		N/A
<b>Performance Management System</b> (required)	<ul style="list-style-type: none"> <li>Develop and implement supporting policies and procedures including <ul style="list-style-type: none"> <li>Performance Management policy and procedure</li> </ul> </li> <li>Develop a “Manager’s Guide” and learning materials for front line managers</li> <li>Train front line managers</li> <li>Engage staff in the development of SMART objectives and competencies and behaviours</li> <li>Develop a web-based performance management system that supports the ongoing needs of the organization (later phase of the project which will have a cost associated with the agreed upon web tool)</li> <li>Implement the system through SharePoint</li> </ul>	HR Paula Rankin	June 30, 2011		N/A
<b>Rewards and Recognition Program</b> (recommended)	<ul style="list-style-type: none"> <li>Develop and implement a rewards and recognition program for all LHIN employees</li> <li>Engage employees in the development of key principles, and program initiatives</li> <li>Implement a program that focuses on contribution and performance</li> </ul>	HR Paula Rankin	June 30, 2013		TBD

LHIN Shared Services Office Projects and Initiatives	Calendar of Projects and Initiatives														
	2011												2012		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Performance Portal Implemetation (TBD)															
Employee Survey															
Financial Systems/Procurement Rebuild Phase II															
Procurement System Development															
Office 2010 Upgrade															
Benefits Program															
Job Evaluation and Comp Design															
Health and Safety Program															
HR Policy Rebuild															
Performance Management Program															
Enterprise Risk Management															
Orientation Program															
PMO															
Rewards and Recognition Program															
SharePoint Implementation - 12 Sites															

# LHIN Collaborative - 2011/12 ABP Submission

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## Background:

The LHIN Collaborative (LHINC) is a provincial advisory structure to the LHINs that engages health service providers, their associations and the LHINs collectively on system-wide health issues related to the LHINs' mandate. LHINC enables the involvement of expertise from all sectors to provide advice on provincial or common areas and provides central support for provincial initiatives.

LHINC is led by a Council of LHIN and health sector representatives and is supported by a secretariat. LHINC is accountable to the LHINs.

LHINC supports the LHINs by:

- Fostering the collective engagement of the HSP community in support of collaborative and successful integration of the health care system;
- Enhancing the LHINs' role as system managers;
- Where appropriate, consistently implementing provincial strategy and initiatives; and
- Identifying and supporting best practices.

## 2011/12 Business Plan

In accordance with its mandate, LHINC's ABP is based on priorities that are identified by LHINC Council and the LHIN CEOs.

The process for identifying key priorities for 2011/12 was started in August 2010 and is not expected to be completed until February 2011. It involves:

- Input from LHINC Council members, health sector associations represented on LHINC Council, and LHINC CEOs and Senior Directors (Aug. – Oct./2010);
- LHINC Council's evaluation and ranking of potential priorities and workplan for 2011/12 (Nov./2010- Feb./2011);
- Assessment of support requirements for high priority LHIN projects (Nov.-Dec./2010); and
- Discussions with LHIN CEOs and their approval of LHINC's 2011/12 workplan (Nov./10-Feb./11)

It's anticipated that LHINC's 2011/12 Business Plan will include three categories of priorities that are detailed in the attached appendix:

1. *LHINs' High Priorities*: LHINC's main concern in 2011/12 will be to support the high priorities that the LHINs have identified to collectively adopt over the next year. LHINC, in consultation with the lead LHIN for each project, is currently assessing the level of support required for the eight projects, but it's anticipated that it will vary, ranging from project management to the execution of specific activities.

2. *LHINC's 2010/11 projects that will continue in 2011/12*: These are projects that are currently active and that will continue in 2011/12.
3. *New Project Priorities*: These are projects priorities that will be identified by LHINC Council.

## Appendix – List of 2011/12 Potential Project Priorities

### 1. LHINs' High Priorities:

- The principle focus of the LHINs' high priority projects is to support the provincial health care plan to achieve Excellent Care for All, and reduce ALC and ER wait times. A common thread is improvement to the quality of care of seniors. Following an initial assessment of the support requirements for each of the eight priorities, LHINC has identified six projects that it could support.
- LHINC is already supporting the following two projects:
  - *Transitions from hospitals – Home First:* Develop a plan to support the implementation of Home First initiatives across the LHINs. It's anticipated that this project will be mostly completed in 2010/11, but there may be a role for LHINC in the implementation across the LHINs in 2011/12.
  - *Falls Prevention Strategy:* Develop a provincial falls prevention strategy in collaboration with the Public Health sector. This project is expected to be completed by May 2011.
- The level of LHINC's support for these four priorities could vary, ranging from project management to execution of specific project activities, and will also depend on LHINC's capacity:
  - *Seniors friendly hospitals:* Enhance the care of seniors within hospitals and reduce the risk of their functional decline while in acute care.
  - *Rehabilitation and Complex Continuing Care:* A review of rehabilitation and complex continuing care services to identify how best to reduce ALC lengths of stay and setting a single, province-wide vision and conceptual framework.
  - *Resource Matching and Referral System (RM&R):* Implement RM&R across the province to streamline and expedite the assessment and referral of patients between various health care provider settings.
  - *Excellent Care for All Act:* Identify the LHINs' role in the implementation of this Act.

### 2. LHINC's 2010/11 projects that will continue in 2011/12:

- The following active projects will continue in 2011/12:
  - *Health System Indicator Initiative:* This is a LHIN-led initiative that brings health system partners together to collectively advance and improve system performance by creating awareness, alignment, and a system focus for indicator identification, development, maintenance, reporting and monitoring.
  - *H-SAA and M-SAA:* Provide process and communications support to the development of new agreements with the respective health sectors.

### 3. New Project Priorities:

- LHINC Council has started the process of identifying priorities for 2011/12. It has developed a preliminary list of priorities and expects to finalize it at its February 2011 meeting.

<b>Template B: LHIN Operations Spending Plan</b>					
<b>LHIN Operations (\$)</b>	<b>2009/10 Actuals</b>	<b>2010/11 Forecast</b>	<b>2011/12 Planned Expenses</b>	<b>2012/13 Outlook</b>	<b>2013/14 Outlook</b>
<b>Operating Funding (excluding initiatives)</b>	<b>829,714</b>	<b>1,364,132</b>	<b>1,370,000</b>	<b>1,370,000</b>	<b>1,370,000</b>
<b>Salaries and Wages</b>	325,387	876,356	918,000	922,030	940,471
<b>Employee Benefits</b>					
HOOPP	35,793	96,399	100,980	101,423	103,452
Other Benefits	46,601	84,363	110,020	111,120	112,231
<b>Total Employee Benefits</b>	<b>82,394</b>	<b>180,762</b>	<b>211,000</b>	<b>212,544</b>	<b>215,683</b>
<b>Transportation and Communication</b>			0.23	0.23	0.23
Staff Travel		2,000	1,000	1,000	1,000
Others	35,785	23,600	32,000	33,576	33,576
<b>Total Transportation and Communication</b>	<b>35,785</b>	<b>25,600</b>	<b>33,000</b>	<b>34,576</b>	<b>34,576</b>
<b>Services</b>					
Accommodation	40,299	94,686	97,000	101,850	104,396
Consulting Fees	206,815	55,150	41,000	41,000	16,873
LSSO Shared Costs		44,400	44,000	44,000	44,000
Other Services	48,965				
<b>Total Services</b>	<b>296,079</b>	<b>194,236</b>	<b>182,000</b>	<b>186,850</b>	<b>165,270</b>
<b>Supplies and Equipment</b>					
IT Equipment	83,692		12,000		
Office Supplies & Purchased Equipment	6,377	87,178	14,000	14,000	14,000
<b>Total Supplies and Equipment</b>	<b>90,069</b>	<b>87,178</b>	<b>26,000</b>	<b>14,000</b>	<b>14,000</b>
<b>LHIN Operations: Total Planned Expense</b>	<b>829,714</b>	<b>1,364,132</b>	<b>1,370,000</b>	<b>1,370,000</b>	<b>1,370,000</b>
	-	-	-	0	0

<b>Template C: LHINC Staffing Plan (Full-Time Equivalents)</b>					
<b>Position Title</b>	<b>2009/10</b>	<b>2010/11 Forecast FTEs</b>	<b>2011/12 Plan FTEs</b>	<b>2012/13 Outlook FTEs</b>	<b>2013/14 Outlook FTEs</b>
<b>Executive Director</b>	1	1	1	1	1
<b>Executive Assistant</b>	0.5	0.5	0.5	0.5	0.5
<b>Administrative Assistant</b>	0	1	1	1	1
<b>Project Consultant</b>	1.5	4	4	4	4
<b>Senior Consultant</b>	2	2	2	2	2
<b>Total FTEs</b>	<b>5</b>	<b>8.5</b>	<b>8.5</b>	<b>8.5</b>	<b>8.5</b>