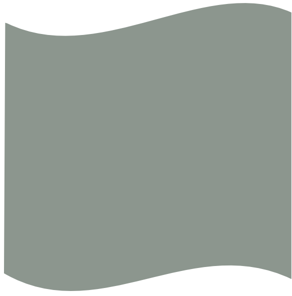

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Appendix 1:
Glossary of acronyms

ALAH – Aging At Home Program

ALC – Alternate Level of Care

BSC – Balanced scorecard

CAISI – Client Access to Integrated Services and Information

CNAP – Community Navigation and Access Project

CRCT – Community Resource Connections of Toronto

ER P4R – Emergency Room Pay for Results program

H-SAA – Hospital Service Accountability Agreement

HAPS – Hospital Accountability Planning Submission

HSP – Health service provider

ICM – Integrated care model; also intensive case management

LGBT – Lesbian, gay, bisexual, transgender, transsexual or two-spirited

LHSIA – Local Health System Integration Act

M-LAA – Ministry – LHIN Accountability Agreement

OCAN – Ontario Common Assessment of Need (mental health common assessment tool)

PSI – Partnerships for Service Improvement

RM&R – Resource Matching and Referral

V & A – Value and affordability

Appendix 2: IHSP-2 methodology

The context for IHSP-2

The legislation that defines the role of LHINs, the Local Health System Integration Act, 2006 (LHSIA), requires each LHIN to create an Integrated Health Service Plan (IHSP) every three years. The first IHSP for the Toronto Central LHIN covered the period from 2007 to 2010. The current Plan, which was submitted to the Ministry of Health and Long-Term care and released publicly on November 30, 2009, covers the period from 2010 through to 2013.

IHSP-2 principles and assumptions

The Toronto Central LHIN 2010–2013 Integrated Health Service Plan is founded on the following principles and assumptions:

Principles	Assumptions

• The IHSP will provide an action-oriented strategic framework owned by the entire Toronto Central LHIN – not just by the team at 425 Bloor Street East.
 	
• The Toronto Central LHIN strategy must be aligned with the MOHLTC priorities of ER/ALC, diabetes, mental health and addictions, system performance, and access to family health care
 	
• The Plan is not starting with a blank slate but rather a focused, efficient process that builds on the first IHSP and the 2008 Roadmap.
 	
• The Plan will be developed through an evidence-informed approach that draws on facts, best practices, the expertise of health service providers and the lived experience of individuals and families.
 	
• The Plan will be driven by a transparent process that invites innovation, criticism, and diverse opinions.
 	
• IHSP-2 must solidify the LHIN's long-term vision, define immediate actionable priorities, and set-out measurable targets for tracking and reporting results.
	A clear goal and a great starting point
	• The overall goal of the health care system should be to create value by helping people stay healthy; providing effective, safe, and high quality services when they need them; and being affordable and accountable to the public.
	• Toronto Central LHIN has a tremendous base to leverage: excellent programs; renowned centres of excellence; leading-edge research and teaching; and a talented and experienced healthcare workforce.
	
	Urgent challenges that need to be addressed
	• The current economic climate has and will continue to constrain health care funding.
	• Chronic disease accounts for the large majority of the LHIN's health care spending and must be managed in a focused, proactive way.
	• There are unmet needs and inequities in access to care.
	• The system does not always work for individuals and their families and does not fully engage them as partners in their care.
	• Health care in the LHIN can sometimes feel disorganized, impersonal and inconsistent from one setting to the next.
	
	The Need for a System-Level Solution
	• A system-wide strategy that increases alignment and integration among all Toronto Central LHIN health providers and strengthen care across the continuum for individuals with the most complex care will:
	  • Increase efficiency, improve quality and enhance the health care experience.
	  • Produce better health outcomes.
	  • Help ensure an affordable and sustainable health care system.
	• Change will take time and the commitment, ideas and effort of everyone in the LHIN: board staff and the public.

A three-phase process

The IHSP-2 process was structured around three phases:

Phase 1 – Scope and frame the strategy

The purpose of Phase 1 was to reach shared agreement on the long-term directions for the Toronto Central LHIN and to begin framing near-term priorities for further analysis and consultation in Phase 2. In spring 2009, the LHIN held a number of forums with board chairs and senior leaders from Toronto Central LHIN health service providers as well as consultations with consumer, community, health care professional and health provider groups. Toronto Central LHIN also commissioned white papers to complement this "wisdom from the field."

Phase 2 – Confirm, refine, and set priorities

Phase 2 began in late May and continued through early September. During this Phase, the LHIN engaged health service providers, patients/clients, local residents and stakeholders to confirm and formulate strategic action priorities. This work was supported by more in-depth analysis of the priority areas identified during the first phase of the process.

Phase 3 – Define success, communicate and act

The final phase focused on defining what success would look like in qualitative and quantitative terms. This work included extensive consultations with health service providers and community members to confirm the overall action plans and definitions of success. The latter part of this phase focused on ensuring all stakeholders understood the strategic directions and on evolving the structures and mechanisms that will support ongoing implementation and system performance management against IHSP-2 priorities.

The balanced scorecard

As part of the process for developing and supporting the Plan, the LHIN adopted the balanced scorecard, a strategic planning and management system that provides a framework for articulating long-term health system goals, defining priorities for action, and measuring results. The balanced scorecard is elaborated on further in Appendix 4.

Many voices, one Plan

It takes many voices and perspectives to create a plan for the local health care system that reflects the whole Toronto Central LHIN community. The 2010–2013 Integrated Health Service Plan is based on direct input from members of the LHIN's communities. The results of this community engagement, along with research evidence, helped define the priorities in IHSP-2. Ongoing engagement over the next three years will further uncover solutions for improving local health services.

In developing this Plan, the Toronto Central LHIN undertook multiple approaches to engagement through special forums, breakfast events, surveys (paper and online) and meetings with health service providers, health care consumers and their families. Here are some examples of IHSP-2 engagement:

- The LHIN hosted several breakfast meetings with health care leaders – CEOs, Executive Directors and Board Chairs of all health service provider organizations funded by the Toronto Central LHIN – to get their feedback on the strategy and priorities for IHSP-2.
- The LHIN worked directly with mental health and addictions agencies to train consumer/survivors and family members to facilitate focus groups with their peers. Input from the focus groups is informing the provincial Mental Health and Addictions Strategy and our local Mental Health and Addictions Action Plan.
- A consultation document and survey were developed for health service providers, health professionals, and consumers. The document outlined overall action plans for each of the IHSP-2 priorities and the proposed approach to measuring success against these plans. The survey provided an opportunity to gauge support for the action plans and definitions of success and to obtain insights for further refinements. The materials were available in French and English and in online and hard copy formats.
- A local family physician, who also chairs the LHIN's Health Professionals Advisory Committee, facilitated discussions on the IHSP-2 priorities with other physicians through a partnership with the Ontario Medical Association and the Ontario College of Family Physicians.

In total, 2,000 individuals participated in and informed the content of IHSP-2.

Appendix 3: Profile of the Toronto Central LHIN today

A dense, urban region that presents both opportunities and challenges

Toronto Central is Ontario's only completely urban LHIN with the densest population – over 6,100 people on average occupy one square kilometer – and the highest concentration of health care providers in the province. This unique makeup presents both opportunities and challenges. The LHIN's concentrated population and relatively greater number of health care providers mean more people can be served closer to home and efforts to improve health can be carried out more efficiently. But high population density also increases pressure on local resources and makes coordination of health services more challenging.

Toronto Central is a region of diversity and extremes. Our population is a mosaic of various nationalities, socio-economic levels, and educational backgrounds. We also boast a diversity of providers and a wealth of community services that address the needs of the different local communities. While our diversity makes for a vibrant city, it also leads to considerable disparities in access and health outcomes, with some

37 % of housing units in Toronto Central LHIN are in high-rise buildings.

groups in the region finding it markedly more difficult to get the care they need or experiencing higher rates of certain types of diseases.

Another unique characteristic of Toronto Central LHIN is that it provides specialized health services to a large number of Ontarians who live in other LHINS. In fact, 52 per cent of care provided at Toronto Central LHIN hospitals were for patients from other parts of the province. This has a considerable impact on local health care resources and health system planning.

Who lives in Toronto Central LHIN?

Toronto Central LHIN is home to about 1.17 million people, or 9.1 per cent of the population of Ontario. Between 1997 and 2007, the LHIN's population grew an average of 0.7 per cent each year, relatively less than the provincial growth rate of 1.4 per cent annually. According to the latest projections, more than 1.23 million people will be living in the Toronto Central LHIN by 2015, accounting for 8.8 per cent of the province's total residents.

A youthful but rapidly aging region

Compared to the rest of the province, a higher proportion of young adults aged 25 to 44 years of age and older live in Toronto Central, representing 33 per cent of the LHIN's population. These young adults generally have the best health and the lowest use of health services. However there has been a trend towards increasing unemployment in the 15 to 24 age group from 12.7 per cent in 2001 to 15.4 per cent in 2006.

Beyond Toronto Central LHIN

Of the LHIN's 281,922 hospital cases from 2007 to 2009, 52 per cent involved residents from outside Toronto Central:

- 48 % of the cases were for Toronto Central residents
- 18% were from Central LHIN
- 13% from Central East
- 21% were from other LHINS

Close to 162,140 infants, children and youth up to the age of 14 live in the Toronto Central LHIN, comprising 15 per cent of the LHIN's population. An estimated 33 per cent of the 13,000 babies born in the Toronto Central LHIN were from low income families, and 55 per cent had a mother who was not born in Canada. About 6.7 per cent of the babies were born underweight, at less than 2,500 grams or 5.5 pounds, and 2.4 per cent had a teenaged mother between 15 to 19 years old.

But while the Toronto Central LHIN has a youthful majority, it also has a higher proportion of older seniors (85 years of age and older). This age group is growing faster than all other age groups in the LHIN, with a projected increase of 48.5 per cent between 2005 and 2015. he population aged 75 and older had increased by 20 per cent between 2001 and 2006 or about four per cent per year.

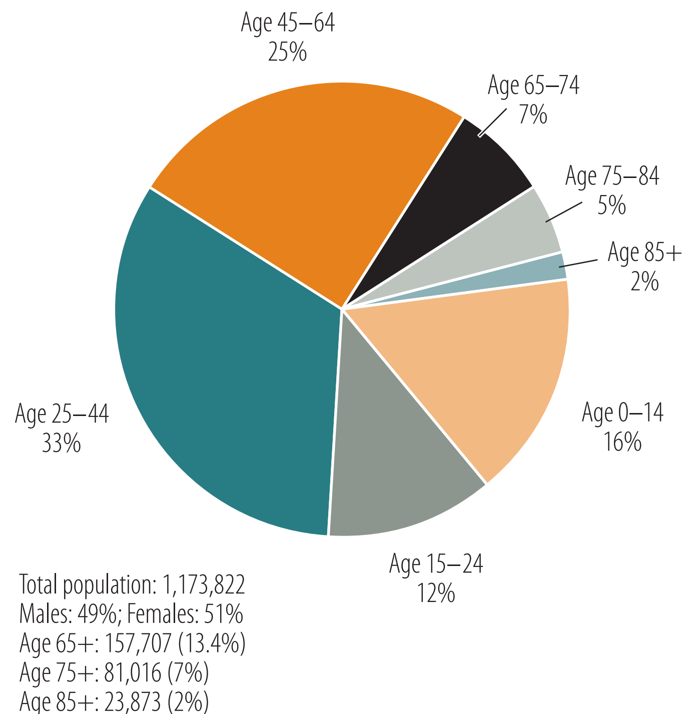
A dense and vibrant population

The Toronto Central LHIN is a vibrant, colourful area peopled by Ontarians from various cultures, socio-economic strata, education and sexual orientation.

- Immigrants in the Toronto Central LHIN: Forty-one percent of the population are immigrants and of this group, 20 per cent are recent immigrants who arrived between 2001 and 2006. The highest proportion of immigrants were from: Southern Europe (19 per cent), Eastern Asia such as the Philippines (13 per cent), South East Asia such as China and Eastern Europe (11 per cent each), and Southern Asia such as India, Pakistan and Sri Lanka (10 per cent). Every country in the world is represented in our population and more than 160 languages are spoken here. About 4.5 per cent of the Toronto Central LHIN residents have no knowledge of English or French.

  Immigrants are screened for health conditions before they are permitted to immigrate, so they are often healthier than the average Canadian. However, language barriers and lack of knowledge of the health care system may create barriers to accessing health services.

- Francophone population: The Toronto Central LHIN has a French-speaking population of about 50,770, a number based on a new definition of Francophones introduced in June 2009 by the Office of Francophone Affairs. Francophones are a group whose composition and needs have been changing in recent years. According to the 2006 Census, 7.4 per cent of Francophones in the City of Toronto – which includes the Toronto Central LHIN – are recent immigrants and 20.6 per cent are part of a visible minority group. These numbers are significantly higher than provincial figures, which showed 1.4 per cent of recent immigrants among Francophones, with 5.1 per cent of visible minorities. The Toronto Central LHIN's Francophone population is also characterized by a growing proportion of seniors and lower income among young families. At the same time, this group has higher education levels compared to Francophone communities in the rest of the province.
- Aboriginal population: According to the 2006 Census, there were approximately 16,200 residents of Aboriginal ancestry (1.5 per cent) of the Toronto Central LHIN population. Other estimates reach up to 23,000 (approximately 2 per cent of the LHIN's population). Aboriginal people have much higher rates of chronic illnesses such as diabetes, arthritis, depression, asthma and heart disease than non-Aboriginal residents. They are also disproportionately represented among the LHIN's homeless population, at between 14 to 16 per cent.
- Lesbian, gay, bisexual, transgendered or transsexual population (LGBT): The Toronto Central LHIN has the largest LGBT community in Canada, with an estimated 10 per cent of the LHIN's population being gay, lesbian, bisexual, transgendered, transsexual, or two-spirited. Members of these communities have distinctive health care needs and can face barriers and issues that need to be addressed and supported by the health system.
- Homeless population: Over 30 per cent of Ontario's homeless population lives in the Toronto Central LHIN, and more than 70 per cent of the indoor and outdoor locations used by homeless people are in the central core of the city. This is a particularly vulnerable group, with 74 per cent suffering from a physical health condition and 33 per cent diagnosed with a mental illness.



Social factors that affect health and access to care in the Toronto Central LHIN

There are wide disparities in income and education levels among communities in the Toronto Central LHIN. Twenty-four per cent of the population are low income, according to the 2006 Census. The proportion ranges from 15.3 per cent to 36.7 per cent among the various areas in the LHIN. The proportion of

Solo acts

30 % of Toronto Central LHIN families with children at home are led by a single parent.

Of these single parent families, 85% are headed by a female parent.

the population without high school education ranges from 6.6 per cent to 18 per cent.

Toronto Central LHIN neighbourhoods vary when it comes to other risks factors for poorer health. For example, the southeast and the north Toronto communities in the Toronto Central LHIN have the highest percentage of the population over age 65 living alone, at 40 per cent and 38 per cent, respectively. Southeast also has 23 per cent of seniors who don't know English or French, and has the highest rate of emergency department visits. The neighbourhood with the highest percentage of new immigrants is northeast at 20 per cent. The northwest area is characterized by a high proportion of seniors with no knowledge of English or French, at 30 per cent.

These and other challenges underline the critical need to achieve health equity in the Toronto Central LHIN – an objective that guides and cuts across all the priorities in IHSP-2.

How healthy is Toronto Central LHIN?

With a large percentage of the population made up of young adults, Toronto Central LHIN's residents are generally healthy. Many residents also engage in activities that are good for health and the environment. About 32 per cent of men and 46 per cent women in Toronto Central take public transit to work while 14 per cent of men and 15 per cent of women travel to work on foot or on a bicycle.

High rates of infectious and chronic diseases

Compared to the rest of the province, the Toronto Central LHIN has a high concentration of infectious diseases, with 66 per cent of Ontario's syphilis cases, 44 per cent of AIDS cases, 30 per cent of gonorrhoea cases, and 24 per cent of tuberculosis cases.

As the population ages, the prevalence of chronic disease is expected to grow. The LHIN's rates for self reported chronic diseases for people living in the community are lower than the rest of the province. Examples: arthritis (12.5 per cent), high blood pressure (13.2 per cent), asthma (6.2 per cent), diabetes (4.2 per cent) and obesity (10.3 per cent). More than one in three of Toronto Central LHIN residents have at least one chronic condition such as diabetes, certain cancers, depression, arthritis, asthma, hypertension and chronic obstructive pulmonary disease. The rates of chronic disease prevalence vary by income level.

Increased hospital admissions and high use of walk in clinics

Since 2005/06, while the self-reported prevalence of arthritis has declined, hospital admissions have increased and this is likely due to more hip replacements. Self-reported hypertension and diabetes have increased as have hospital cases for these conditions. Again this is likely due to the increase in the population aged 65 and older. Self-reported prevalence and hospital cases for asthma have decreased. Cancer and stroke hospitalizations have also decreased.

A high proportion of the population have a general practitioner (GP), and half can get an appointment with their physician within one day. There is a high use of walk in clinics and low use of emergency departments in the Toronto Central LHIN. The length of time to get an appointment may be driving use of walk-in clinics. Walk-in clinic use may be higher than reported as this data do not include individuals who are not attached to a GP practice.

Diabetes, mental health and addiction: Serious concerns for Toronto Central LHIN

Diabetes is of particular concern to the Toronto Central LHIN, which has a high prevalence of the disease. Almost 10 per cent of LHIN residents aged 20 and over suffer from diabetes. But these numbers are likely to be even higher, since many people with diabetes are unaware they have the disease.

Income, education and employment in Toronto Central LHIN – a picture of extremes

24 % of Toronto Central LHIN residents earn low incomes.

34 % of adults in Toronto Central LHIN have a university degree, compared to 19 per cent for the province.

7.5 % of working-age adults in Toronto are unemployed. The provincial rate is 6.5 per cent.

Mental illness and addictions have also become serious health issues for the Toronto Central LHIN. Mental illness will affect 20 per cent of people in the Toronto Central LHIN in their lifetime. Prevalence is higher among those aged 65 and over. Aboriginal people in the LHIN, and people who are homeless or living in poverty also have higher rates of mental health issues and addiction than the general population.

What health services are available in the Toronto Central LHIN?

The Toronto Central LHIN has the highest concentration of health services in Canada, with 177 agencies and more than 42,000 health care workers. The LHIN's size is reflected in its base budget of $3.96 billion, provided by the Ministry of Health and Long-Term Care. With this budget, Toronto Central LHIN is responsible for funding various agencies such as hospitals, community care access centres, community health centres, long-term care homes, community support services and services to support patients with mental health problems and addictions. Not all health service providers in the region fall within the mandate of the Toronto Central LHIN.

The Toronto Central LHIN's base budget accounts for 20.6 per cent of the province's total base budget for health services. Many of the LHIN's health agencies, most especially hospitals, provide a significant proportion of specialized services to patients who live outside Toronto Central LHIN.

What health agencies fall under the mandate of the Toronto Central LHIN?

Hospitals

A large portion of Toronto Central LHIN's base budget goes to hospitals, which receive $3.3 billion a year, or 83.7 per cent of the budget. The Toronto Central LHIN's 18 hospitals have 6,655 acute, chronic, rehabilitation and mental health beds and account for 2.2 million total patient days.

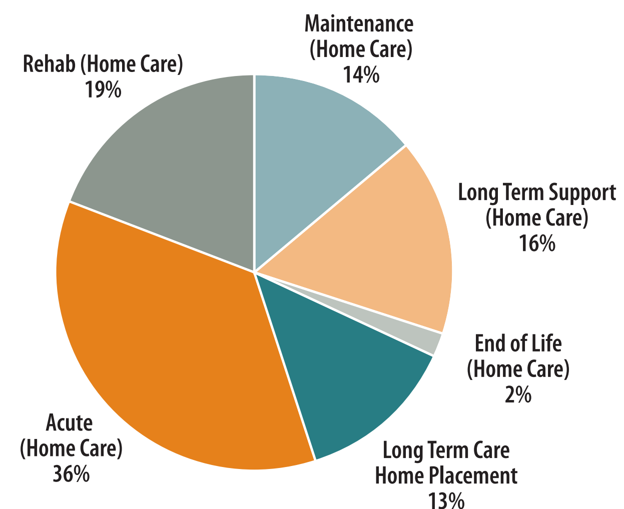
A number of hospitals in the Toronto Central LHIN provide specialized services not offered anywhere else while also training future health care providers and conducting research. As examples, the Toronto Central LHIN is home to:

- Toronto Rehabilitation Institute, the largest adult rehabilitation hospital in Canada
- Bloorview Kids Rehab, Canada's largest children's rehabilitation hospital
- Centre for Addiction and Mental Health, Canada's largest mental health and addictions treatment facility
- World-renowned names like the Hospital for Sick Children and Princess Margaret Hospital, which have been the source of multiple world-firsts in both research and care delivery
- Canada's greatest concentration of health sciences research and one of North America's largest health sciences research complexes

Community Care Access Centres

Community Care Access Centres (CCACs) assess people's needs and arrange for services such as home care, caregiver relief, placement in long-term care homes, referral to transportation, day programs, homemaking and meal services. In 2008/09, the Toronto Central CCAC provided 2,878,600 visits/hours of care and care coordination to over 53,600 individuals using a budget of $167.4 million. Ontario's CCACs have been reorganized so there is now one CCAC in every LHIN.

Admissions for Case Management to Toronto Central CCAC 2008/2009



Source: CCAC Comparative Reports 2008/2009
Ontario Healthcare Financial Databse, MOHLTC

Community Health Centres

One third of the province's community health centres (CHCs) are located in Toronto Central LHIN, with 18 centres and six satellite program sites operating on a combined budget of $65.8 million. CHCs serve people with high care needs such as isolated seniors, low income families, street youth, homeless people, and people experiencing language barriers or discrimination. In 2008/09, CHCs in the Toronto Central LHIN provided 259,400 primary care visits to over 77,000 people. CHC community programs range from diabetes groups, harm reduction, Early Years programs, women's health, wellness, outreach to socially isolated seniors and environmental action.

Community support organizations

Community support organizations provide a wide range of services including home care for the sick and elderly, shelter for victims of abuse, transportation and meal services, support for the homeless, settlement assistance for immigrants and refugees, training and other employment support for the jobless, after school programs, supportive housing, youth programs, respite programs including caregiver respite and adult day programs, and mental health services. Sixty-eight community support organizations in the Toronto Central LHIN provided an estimated 666,270 visits to about 302,960 people in 2008/09, operating on a budget of $78.8 million.

Mental health, addictions and problem gambling services

The Ministry of Health and Long-Term Care funds 66 mental health and addictions programs in the Toronto Central LHIN to provide mental health, addictions and problem gambling services, operating on a budget of $109 million. Two of these organizations have the mandate to serve people from across the province.

Long-term care homes

There are 37 long-term care homes in the Toronto Central LHIN, operating on a combined budget of $224 million. With about 5,970 beds, these homes accounted for almost two million resident days in 2008. Long-term care homes are for people who need 24-hour nursing care and

By the numbers: Toronto Central LHIN health service providers

Table -: Health Service Providers Within the Mandate of the Toronto Central LHIN, 2009*

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

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

supervision within a safe environment. Long-term care homes offer higher levels of personal care and support than supportive housing. Although long-term care homes are owned and operated by different organizations and can be for-profit or not-for-profit, the Ministry of Health and Long-Term Care sets standards for care and inspects long-term care homes each year.

Note: Some health service provider agencies provide multiple services i.e. community support and mental health and addictions.

Planning and coordinating services: The challenges for the Toronto Central LHIN

A complex range of services spread unevenly across the LHIN

A large number of health organizations operate in the local area, not all funded by the Toronto Central LHIN. For example, physicians bill directly to OHIP. While the diversity of services respond to the unique community needs in the LHIN, the complex range and number of services in the Toronto Central LHIN present challenges in bringing organizations together and coordinating care when clients are transferred from one agency to another. Uneven distribution of health service providers across the LHIN is also a problem that leads to inequitable access to care for Toronto Central residents. For example, there are fewer diabetes education programs and centres in the some areas of the LHIN.

Lack of comprehensive health services activity data

Another challenge is the lack of comprehensive information on many of the organizations in the Toronto Central LHIN; larger organizations such as hospitals tend to have more information on their activities than smaller organizations. From a health system planning perspective, this makes it difficult to identify and assess needs, and evaluate whether services are making a difference.

A shortage of health human resources – an international issue

Another significant challenge: a shortage of health human resources. The rate of growth in the numbers of family physicians, specialists and nurses in Ontario is not keeping up with the growth of the population – a problem reflected in the Toronto Central LHIN. Exacerbating this problem is the fact that Ontario's health care workforce is aging. In its 2003 Annual Health Care Provider Labour Market Survey, the Ontario Hospital Association reported that 42.3 per cent of health care workers in the province were 45 years or older, with about a quarter of expected to retire over the next five years.

Compounding the problems of diabetes

Left untreated, diabetes can lead to other health problems.

- 76 % of people diagnosed with diabetes had at least one additional chronic condition.
- 42 % had two or more chronic conditions.
- 53 % had hypertension.
- 40 % had arthritis or rheumatism.
- 21 % had heart disease.

What is the state of education and research in the Toronto Central LHIN?

One of the distinguishing characteristics of the Toronto Central LHIN is the breadth, depth and significance of the education and research that take place within its boundaries that have local, provincial, national and global impact. Although universities and colleges do not fall under the authority of LHINs, health-related education and research are critical to efforts to sustain and improve the health care system.

A provincial leader in training health care providers

With a tripartite mission of teaching, research and clinical care innovation, academic hospitals provide a crucial link between academic institutions and real-world settings where health care providers work. Ontario has 25 academic hospitals training 90 per cent of the province's health care providers. With 10 academic hospitals within its boundaries, Toronto Central is the provincial leader in training health care providers.

Education and research in the Toronto Central LHIN schools

The Toronto Central LHIN includes:

- The University of Toronto – which is home to the largest medical school in the country – and its affiliated institutions of hospitals, research institutions, providers and laboratories.
- The Michener Institute, the only post-secondary institution in the country devoted to educating applied health professionals such as medical radiation technologists and anaesthesia assistants.
- Ryerson University, a leader in career-focused education with more than 80 graduate and undergraduate programs.
- George Brown College Centre for Health Sciences, whose mission is to be the first choice provider of lifelong education to health and community service professionals.

Education and research in academic hospitals

Academic hospitals are responsible for at least eight per cent of the Toronto Central LHIN's health research activity. The total research investment of all these facilities – combined with the University of Toronto's Health Science Faculties – is more than $1 billion annually. These facilities also train, on average, over 13,000 students each year.

In addition to these facilities, research is also conducted at other teaching hospitals in the Toronto Central LHIN including Baycrest Centre for Geriatric Care, Mount Sinai Hospital, St. Michael's Hospital, Sunnybrook Health Sciences Centre, Women's College Hospital, and Centre for Addiction and Mental Health.

In 2010, St. Michael's Hospital will celebrate the opening of the Li Ka Shing Knowledge Institute, a trailblazing facility which will bring together leading edge research and new models of education to shape the future of medicine and bring advances in health care to patient bedsides faster than ever before.

Additional research and teaching are conducted in the LHIN's community hospitals, and other research centres such as the Medical and Related Sciences (MaRS) Discovery District research centre, the Institute for Clinical Evaluative Sciences, and Cancer Care Ontario.

The Toronto Central LHIN also has a robust community-based research capacity. Nearly 50 organizations reported active involvement in community-based research in a 2008 study and the Toronto Community Based Research Network has more than 200 members. A number of the LHIN's health service providers are recognized leaders on the provincial, national and international stages in developing approaches to remove access barriers and improve health outcomes for diverse communities.

Challenges and opportunities for health education and research in the Toronto Central LHIN

The wealth of health education and research activities in the Toronto Central LHIN offers tremendous possibilities for improving health care services. To take advantage of these opportunities, the Toronto Central LHIN needs to improve the transfer of research knowledge from laboratories and into the field. At the same time, users of services, planners and policy makers need to influence the kind of research undertaken in the Toronto Central LHIN and ensure that health care provider education meets the needs of the population and support innovation in health care.

In the current economic climate, however, funding limitations will constrain the ability to hire and cultivate scientific talent.

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Appendix 4: Tracking overall system performance – Developing the Toronto Central LHIN balanced scorecard

Why a Toronto Central LHIN balanced scorecard?

Early in the IHSP-2, the Toronto Central LHIN adopted the "balanced scorecard" as a tool to support strategy development and performance management. First developed by Robert S. Kaplan and David S. Norton in 1992, balanced scorecards have been adopted by thousands of for-profit and not-for-profit organizations worldwide.

The concepts of the balanced scorecard (BSC) are attractive for the Toronto Central LHIN because they offer a framework to design, communicate, implement, and monitor overall strategy execution. Moreover, because many health service providers are now using the BSC framework, there is an opportunity to build on an increasingly common language and approach throughout the LHIN. This common language will help facilitate dialogue throughout the LHIN about what we are trying to accomplish as a "system."

The anchor of a balanced scorecard approach is the "strategy map." Strategy maps are a way of providing a one-page picture of an organization's strategy. This strategy map in and of itself provides tremendous value as a communication tool and as a tool for defining the collective "strategic objectives" that together will enable all players in the Toronto Central LHIN system to deliver on a shared vision and goals. Once defined, the strategy map can be translated into operational activities, priorities and performance metrics.

The "balance" in balanced scorecard refers to the recognition that to achieve a comprehensive picture of an organization's strategy and performance, it must be seen from different viewpoints or perspectives. Balanced scorecards (and strategy maps) are typically organized around four "perspectives." The Toronto Central LHIN balanced scorecard has kept this concept of multiple perspectives but has modified the language and conceptualized the perspectives as "value to the public" and "system functions" as shown in Figure 1.

Figure 1

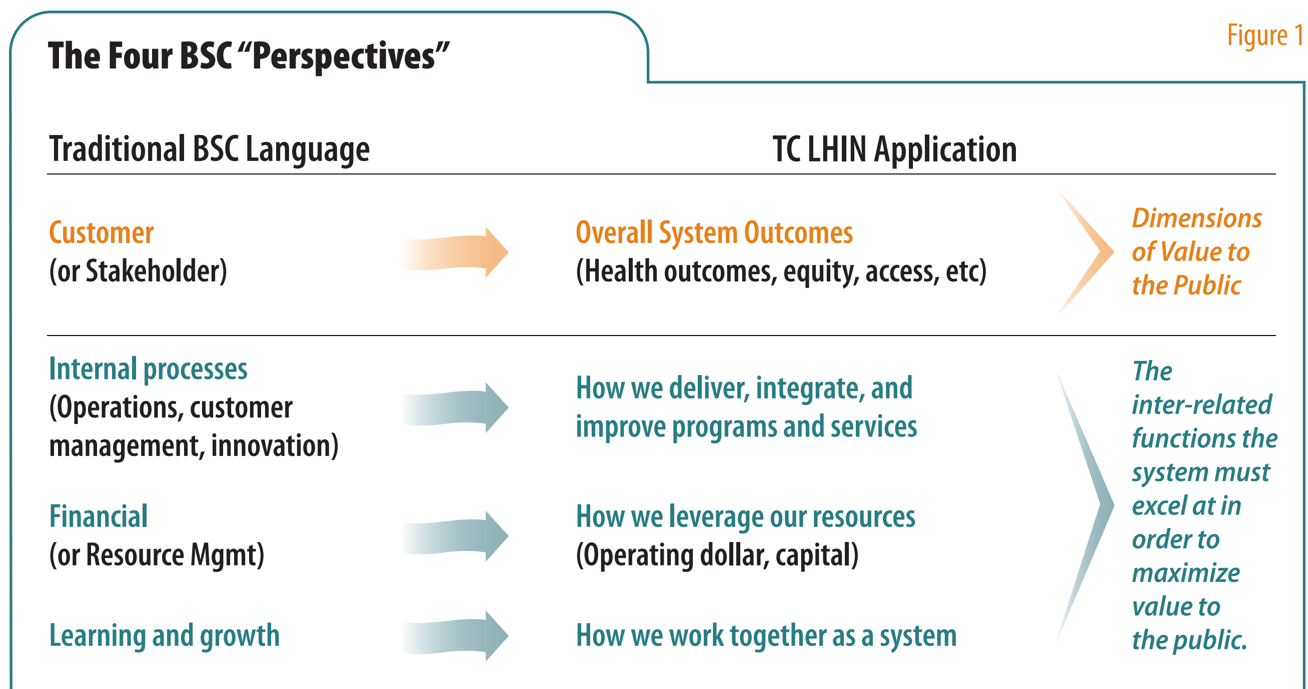
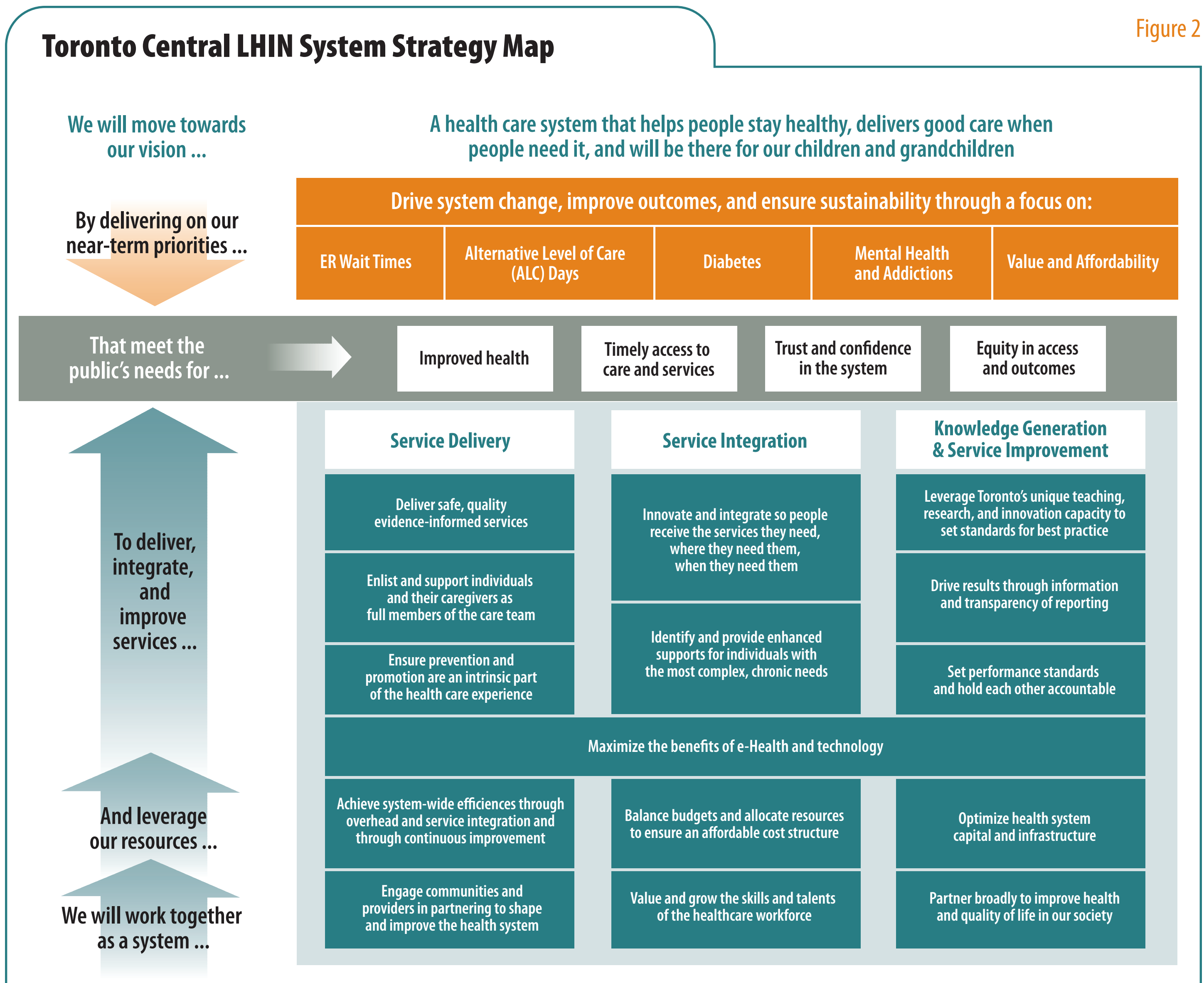


Figure 2



The Toronto Central LHIN strategy map

Over the course of Phase 1 of the IHSP-2 process, the Toronto Central LHIN undertook extensive conversations with health service providers and health consumers on the shape, language, and contents of a LHIN-level system strategy map. The resulting strategy map is shown in Figure 2.

The backbone of the strategy map is the grey bar near the top of the page which depicts the four overall dimensions of value that the Toronto Central LHIN system must deliver to the people it serves:

- Improved health
- Timely access to care and service
- Trust and confidence in the system
- Equity in access and outcomes

The lower part of the strategy map illustrates the 15 inter-related functions Toronto Central LHIN must excel at in order to deliver the four outcomes of value to the public. These include quality and safety, prevention and promotion, teaching and research, and e-health. These and the other functions highlighted in the Toronto Central LHIN strategy map are essential to achieving the priorities in IHSP-2.

Strategy is anchored in a clear vision and is described by a clear picture of the "moving parts" as depicted in the strategy map. However, strategy is not accomplished by trying to do everything at once but rather by focusing on a clearly defined set of priorities at any given time. Hence, the bar at the top of the strategy map contains the five priorities Toronto Central LHIN is committing to in IHSP-2.

Using the balanced scorecard to track, measure and manage overall system performance

Each year, the Toronto Central LHIN will develop its Annual Business Plan which will translate overall action plans and objectives from IHSP-2 into specific milestones, indicators, and targets for the coming year. The Toronto Central LHIN will report each quarter on progress and outcomes against this Annual Business Plan.

Starting in 2011/12, the Toronto Central LHIN will publish an annual report on system performance which will complement the Annual Report that the LHINs submit to the legislature. This report will include performance against the Annual Business Plan for the prior year and performance against the four outcomes and 15 system functions on the Toronto Central LHIN system strategy map. Given the complexity of determining indicators and obtaining information, reporting will be phased in over the three years of IHSP-2.

Figures 3 and 4 provide an overview of the intended approach to developing this annual system performance report against the overall balanced scorecard. The column on the right indicates when reporting for outcome/system function will begin but in many cases reporting of all dimensions described under "measurement

Figure 3

Value to the Public		
Dimension of Value to the Public (Outcomes)	**Measurement Approach**	**Target Timing to Begin Reporting**
Improved health	Engage individuals with expertise in this area to reach consensus on what two or three indicators of health status that are already collected (through Health Canada, Institute for Clinical Evaluative Studies, other bodies) are most meaningful to report on an annual basis. Identify one or two indicators of health status specific to IHSP-2 priority populations through the Diabetes and Mental Health & Addictions Steering Committees	2012/13
Timely access	Report wait time performance on all province-wide wait time priorities (cancer, MRI, CT, cataracts, hip and knee replacements, cardiac surgery, ERs, ALC, LTC placement Develop a small number of indicators for access to community-based services to be incorporated into future accountability agreements.	Underway 2011/12
Trust and confidence in the system	Work with the province and other LHINs and stakeholders to identify an approach to tapping into existing provincial surveying processes to secure LHIN-level data relating to this objective	2011/12 or sooner
Equity of access and outcomes	Work with providers and consumers to develop priorities and an approach to collecting health equity information and to reach consensus on the two or three indicators of health equity that would be most meaningful to report on a system level.	2011/12

approach" may not be in place until the end of 2012/13. The remaining health system functions are less easily measured through quantitative indicators. Rather, in IHSP-2, a mix of approaches will be used to obtain an annual assessment of system progress in these areas. Assessment will draw upon qualitative feedback from LHIN steering committees, panels, forums, and other vehicles. In several cases, the Toronto Central LHIN Community Engagement Network will be asked to solicit feedback from health care consumers. This Network is composed of community engagement/stakeholder relations experts from Toronto Central LHIN health service provider organizationss who work with residents and clients in their respective communities. Targeted surveys and focus groups may be undertaken.

These remaining health system functions are:

- Enlist and support individuals and their caregivers as full members of the care team.
- Ensure prevention and promotion are an intrinsic part of the health care experience.
- Innovate and integrate so people receive the services they need, where they need them, when they need them.
- Identify and provide enhanced supports for individuals with the most complex, chronic needs.

Figure 4

Health System Functions

Five health system functions shown on the strategy map can be captured quantitatively with existing or obtainable measures. Reporting for three of these functions will include an overall indicator(s) as well as indicators relevant to one or more of the IHSP-2 priorities.

Function	Measurement Approach	Target Timing to Begin Reporting
Deliver quality, safe, evidence-informed services	Seek guidance from the Ontario Health Quality Council (OHQC) on what one or two indicators would be most meaningful at a LHIN level.	2010/11
	Identify two or more indicators that can be tracked relating to quality and safety in community services and incorporate into future accountability agreements.	2011/12
Set performance standards and hold each other accountable	Report on the proportion of health service providers that are on track with their accountabilities as outlined in the accountability agreements. (Level of reporting will require further examination but may include reporting at an overall level, by sector, and by type of accountability.)	2010/11
Achieve system-wide efficiencies through overhead and service integration and through continuous improvement	See indicators listed under the "Value & Affordability" Action Plan in Part II of this document.	2010/11
Maximize the benefits of eHealth and technology	Track and report activity-based measures that reflect level of electronic access to information. Potential indicators: % of all referrals being made electronically; % of clinicians able to access lab results electronically; % of clinicians receiving electronic discharge summaries; # of clients in diabetes registry; etc.	2011/12
Balance budgets and allocate resources to ensure an affordable cost structure	The Toronto Central LHIN will report on the proportion of health service provider organizations that have completed the reporting year with a balanced budget *and have met targeted volumes for services provided.*	2010/11

- Leverage Toronto's unique teaching, research, and innovation capacity to set standards for best practice.
- Drive results through information and transparency of reporting.
- Optimize health system capital and infrastructure.
- Engage communities and providers in partnering to shape and improve the health care system.
- Value and grow the skills and talents of the health care workforce.
- Partner broadly to improve health and quality of life in our society.

Appendix 5: Three year milestones for IHSP-2

The following table presents the milestones associated with Toronto Central LHIN's actions on each of its IHSP-2 Priorities.

The assumptions about the actions (and the corresponding milestones below) and their impact on outcomes are based on the best available information and insights at the time the Plan was developed. Success will be measured against outcomes on the LHIN's performance measures described in Section 7 of the IHSP-2. The LHIN is committed to continually strengthening the reliability and currency of its performance measures and to evaluating performance based on outcomes whenever possible. The specific interventions and indicators will be further refined and developed as part of the Annual Business Plan process

Note: Expected outcomes are in ***bold italics*** to distinguish them from activity milestones.

IHSP-2 Priorities

	2010/11	2011/12	2012/13
ER/ALC	Standardized intake in place for all seniors clients of CSS agencies and electronic intake process (RMR) initiated. Mechanisms in place to identify at risk seniors in all acute care hospitals. Expand Integrated Care Model (ICM) to involve all acute care hospitals. Enhance community capacity to support transition of seniors from ER/ALC eg. supportive housing, convalescent care. Identify priorities for reducing risk of functional decline for seniors while in acute care. Ongoing process redesign activities and focus on discharge planning enabling majority of hospitals to meet ER targets.	Expand RM&R to include other targeted sectors and/or populations. Expand mechanisms for identifying at-risk individuals to additional sectors and/or populations. Increase the number of individuals benefitting from ICM by expanding it to include other settings and/or populations. Incorporate priorities relating to preventing functional decline for seniors into hospital accountability agreements. ***All hospitals meeting ER targets and most hospitals meeting ALC targets.***	80% of all TCLHIN HSPs engaged in the Resource Matching & Referral Program. Benefits realization review completed of Integrated Care Model, Aging at Home and other investments and action priorities confirmed for next three years. Monitor outcomes from senior's care initiatives and determine priorities for the next three years. ***All hospitals meeting ER targets and ALC targets.***
Diabetes	Screening and outreach program in place in high needs neighbourhoods in NE and NW of LHIN. Increase access to team-based care through expansion of Diabetes Education Programs beginning with high risk neighbourhoods and populations (eg. Aboriginals). Regional Diabetes Coordination Centre established. Baseline diabetes dataset established, performance targets set, and primary care providers begin to receive reports. See eHealth for actions relating to the Diabetes Registry.	Evaluate outcomes from NE and NW screening and outreach programs and set priorities for further expansion. Implement primary care engagement strategy in high needs neighbourhoods. ***Over half of primary care providers receiving reports on adherence to evidence-based guidelines.***	Expand screening and outreach programs to additional high needs neighbourhoods. ***At least three standardized care processes in place between primary care and specialty care throughout the LHIN.*** ***Majority of primary care providers receiving reports on adherence to evidence-based guidelines.*** Benefits realization review completed to assess outcomes from all diabetes initiatives and priorities set confirmed for next three years.
Mental Health & Addictions (MHA)	Define common intake and referral form to be used for all mental health and addictions providers. Implement common assessment tool in majority of community mental health agencies. Complete roll-out of Integrated Care Model for individuals with complex and chronic addictions. Complete the Performance Management and Accountability Framework and put processes in place to address data gaps. Initiate cross-sectoral forums to propose integration and coordination solutions for priority populations.	Begin implementing common intake and referral form. Evaluate outcomes for individuals in the ICM model and set priorities for further expansion. Set performance target based on initial data from the Framework. Complete cross-sectoral forums and continue implementation of system solutions to respond to unique population needs.	***Common intake and referral forms being used by all MHA providers.*** Benefits realization review of common assessment tool and investments in coordinated access and priorities defined for next three years. Expand ICM model to other targeted MHA populations. Evaluate performance versus targets and update priorities for the next three years. Continue cross-sectoral dialogue and implementation of system solutions for priority populations.

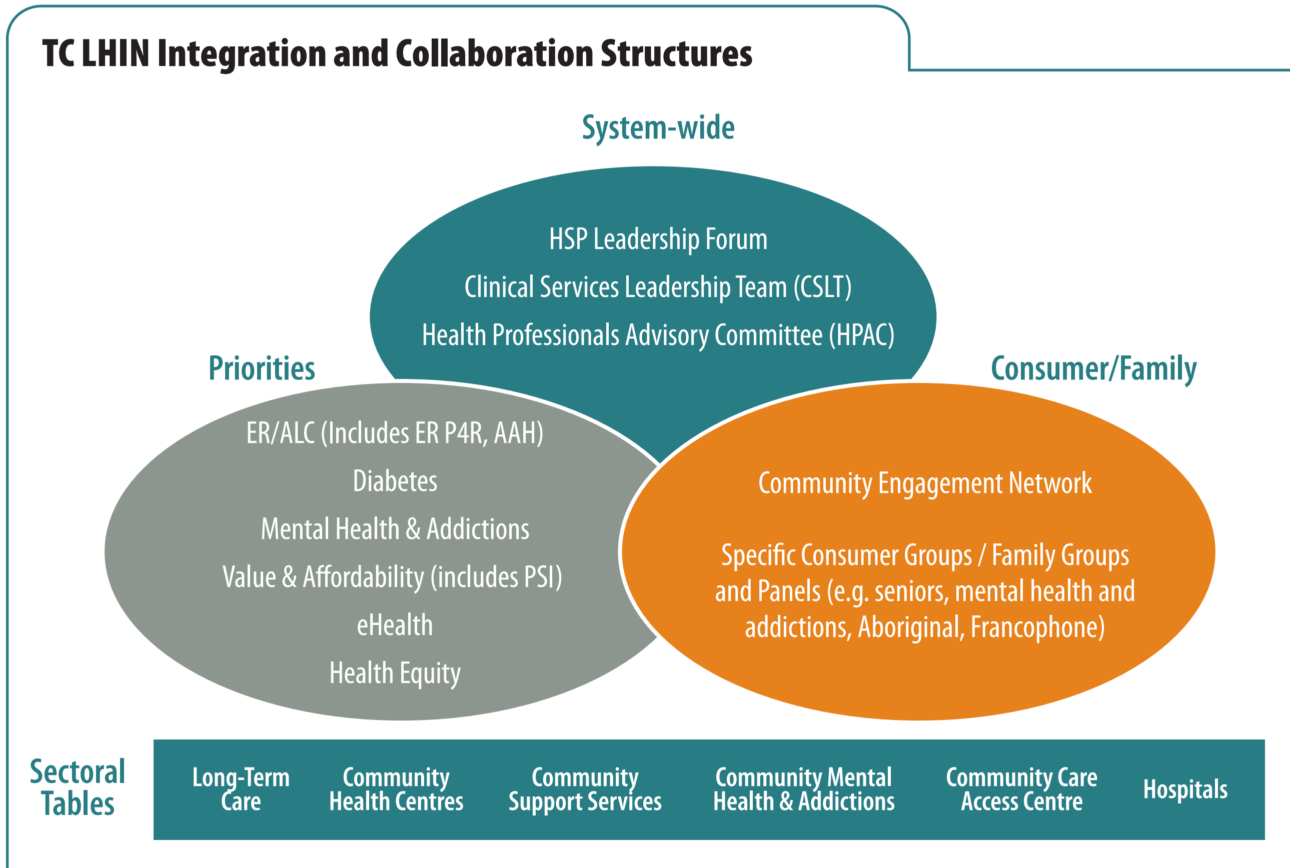
Enablers and Other Supporting Action Plans

	2010/11	2011/12	2012/13
Value and Affordability	***Achieve full benefits realization on Phase 1 Partnerships for Service Improvements (PSI) projects.*** Announce Phase 2 PSI projects – triple # of HSPs engaged in partnerships by year-end. Complete business plans and early implementation of HAPS V&A initiatives. Initiate Clinical Efficiency & Utilization review in the hospital sector. Complete V&A task forces in the non-hospital sectors, identify priorities, and begin business plans.	***25% of all HSPs engaged in two or more back-office partnerships.*** Produce a benefits realization report and interim evaluation of PSI projects. Achieve lab, pharmacy, and other milestones arising from HAPS V&A business plans. Complete Clinical Efficiency & Utilization review and begin implementation. Complete V&A business plans for non-hospital sectors and begin implementation.	***40% of all HSPs engaged in two or more back-office partnerships.*** ***Have achieved demonstrable V&A gains in all sectors.***
eHeath	All foundational elements in place to support integration projects (i.e. Resource Matching & Referral; ConnectingGTA; GTA West Diagnostic Imaging Repository; etc.): • Project oversight in place • Technical solutions procured • Care and related processes re-designed, as required. Care model developed to drive implementation plan for the provincial Diabetes Registry.	Selected types of clinical data now available across the Toronto Central LHIN (and GTA), i.e. lab results, discharge summaries, referral information. Resource Matching & Referral program expanded to large proportion of community agencies. Diabetes Registry implementation well underway	Majority of health service provider organizations and clinicians can access integrated patient information to support continuity of care and decision making. 80% of all TCLHIN HSPs engaged in the Resource Matching & Referral Program. Majority of individuals living with diabetes in Toronto Central LHIN are identified through the provincial Diabetes registry. Implementation of patient portal initiated.
Health Equity	Launch interpretation project. Incorporate Health Equity obligations in hospital accountability agreements. Confirm what equity indicators should be tracked to inform progress on IHSP-2 priorities.	Expand reach of the interpretation project. Begin to track and report on health equity indicators as defined in year 1. Initiate use of health equity impact assessment tool for decision making beginning with Aging at Home.	Shared service for LHIN-wide interpretation fully in place Health equity plans in place for community agencies and health equity obligations incorporated in all accountability agreements. Information available to gauge the impact of IHSP-2 priorities on vulnerable populations.
Other	LHIN structures for consumer and HSP engagement strengthened and in place. Launch of annual survey of HSPs on level of collaboration and systems thinking occurring within the LHIN.	First annual report on system performance available. First publication of two or three system-level indicators of quality & safety.	Community-version of annual report on system performance published. Evidence of increased public confidence in the health system and increased consumer engagement in health system decisions.

Appendix 6: Engagement approaches and structures

Engaging communities and providers to shape and improve the health system

Just as advisory groups were critical in developing this Plan, implementing and measuring its initiatives will also be carried out through consultations and collaboration. The Toronto Central LHIN is refining the structures and approaches used to advise the LHIN and implement the IHSP-2 actions.



Through the provider groups, the LHIN will seek advice related to overarching strategy and performance issues, how best to implement the IHSP-2 action plans, and issues affecting regular operations. These groups will play a pivotal role in ensuring the health service providers responsible for delivering services in the Toronto Central LHIN are key partners with the LHIN in delivering IHSP-2.

The consumer/family groups have an equally critical role. These groups provide the LHIN with insight into the needs of targeted populations (e.g. Aboriginal, Francophone), as well as persons directly affected by the work in IHSP-2 (i.e. consumers and families of persons with mental illness and/or addictions).

Francophone and Aboriginal engagement

Francophone engagement

The Toronto Central LHIN regularly engages local Francophone agencies and other stakeholders through participation in the Toronto Region French Language Services Committee, and by working collaboratively with the five Greater Toronto Area (GTA) LHINs (Mississauga Halton, Central West, Central East, Central and Toronto Central) to develop effective Francophone engagement strategies for enhancing French language services throughout the GTA.

Francophone engagement is guided by the Local Health System Integration Act 2006, which requires the LHINs to adhere to the French Language Act by offering health services to the Francophone community in French. In June of 2009, a new inclusive definition of Francophone was introduced, increasing the total number of Francophone people in the Toronto Central LHIN to about 50,770.

Better data and research are needed in order to understand the needs, challenges, successes and gaps related to Francophone health care services. Working together with the Toronto Region French Language Services committee, the Toronto Central LHIN will further engage various Francophone groups to produce an inventory of existing studies and consultations, and identify needs and strategies for enhancing French language services in Toronto and the GTA.

Aboriginal engagement

The Toronto Central LHIN regularly engages local Aboriginal agencies and other stakeholders through participation in various Aboriginal advisory committees, meetings and networks, such as the Urban Aboriginal Health Roundtable and the Centre for Addiction and Mental Health (CAMH) Aboriginal Services Advisory Committee.

Aboriginal engagement is guided by the Local Health System Integration Act, 2006 (2006), which requires the LHINs to respond to the needs, priorities and health service delivery issues of local Aboriginal peoples and communities.

Based upon Aboriginal community engagement interviews and consultations, it was determined that the most effective strategy is to combine population-based planning across the GTA LHINs. As a result, all five GTA LHINS are working together with the Aboriginal communities to plan services targeted to urban Aboriginals rather than having five distinct local health planning entities within the GTA.

Aboriginal community engagement to date has uncovered health priority areas and the most effective approaches needed to address priorities. These include a focus on mental health and addictions, diabetes, and improving services geared towards a youthful population and those populations who remain hidden to service providers (e.g. homeless and middle class).

The five GTA LHINs are working towards establishing a mechanism for local health planning, such as an Urban Aboriginal Health Council, seen in some other LHINs.

Aboriginal community engagement approaches are based upon principles directed by and for the Aboriginal community in order to foster more respectful and collaborative relationships among the Aboriginal community and the LHINs, and to improve trust, communication, transparency, accountability and reciprocity.