

Toronto Central **LHIN**

Roadmap

November 19, 2008

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1) Goal

Toronto Central Local Health Integration Network's (LHIN) directions will focus on delivering positive change to ensure that people living with chronic diseases – particularly mental health, addictions and diabetes – have the services and supports necessary to stay healthy. At the same time, the LHIN will continue to maintain and improve the local health system performance.

Specifically, the LHIN will aim to achieve the following results:

1. Reduce incidence of emergency room visits where main diagnosis is mental illness and/or addictions.
2. Reduce length-of-stay in hospital for patients with mental illness and/or addictions.
3. Reduce the rate of diabetes-related complications.
4. Meet our health system performance goals, as described in the Ministry LHIN Accountability Agreement (MLAA) and other accountability agreements, in particular Emergency Department Wait Times.
5. Measure to improve client satisfaction.

Key Assumption

Any change in the financial status of the Ministry or of the LHIN's health service providers (HSP) may affect the ability to implement Roadmap activities.

Measuring Results

Ultimately, the Roadmap is designed to improve outcomes for the health care system for consumers and patients. However, because system and patient outcomes can take significant time to achieve and to evaluate, the LHIN will also use interim process indicators to demonstrate the progress towards the achievement of the outcomes goals. Wherever possible, the LHIN will measure and report on system and patient outcomes that can be achieved within the timeframe of this Roadmap. The tables in Appendices C, D and E include both process and outcomes indicators for priority interventions.

2) Strategic Priorities

2.1 Reduce escalation of acuity of people with mental illness and/or addictions

Goals

- Reduce incidence of emergency room visits where main diagnosis is mental illness and/or addictions.
- Reduce length-of-stay in hospital for patients with mental illness and/or addictions.

Approach

The Ministry is currently developing its mental health and addictions strategy and has struck a Ministry-LHIN Mental Health and Addictions Working Group. While the LHIN will participate in the Working Group, it is proceeding with its own mental illness and addictions action plan, designed to reduce the escalation of acuity for people with mental illness and/or addictions. Three key interventions will help avert emergency room visits and hospitalizations:

1. Increasing capacity in areas of known need.
2. Establishing a coordinated point of access.
3. Establishing a process to share clinical information across providers.

The Toronto Central LHIN will undertake further planning and program development while implementing the interventions listed above. The LHIN will assess data to determine which mental illness and/or addictions diagnoses are most frequently found in the emergency department and the referral practices of and community-based services provided to these clients, and will ask experts in the field to validate the issues that emerge from the data.

Progress to date

The LHIN has made initial investments in areas of known need, particularly in services to support high-risk and marginalized seniors:

- Coordinated Point of Access - Mental Health and Addictions Supportive Housing common process development.
- Seniors Mental Health and Addictions Services Standardization Projects – 1) Hospital, and 2) Community.
- Client Access to Integrated Services and Information (CAISI) - Expansion of an information system that facilitates sharing homeless clients' medical information.
- Supportive Housing – 1) Neighbourhood Link, and 2) City of Toronto.

Interventions

In addition to the initiatives funded or underway, the following interventions are planned or awaiting formal approval.

Coordinated Point of Access. This involves the creation of standard intake and assessment supported by electronic tools. The first deliverable is a standardized process for supportive housing and related services. The coordinated access model will be expanded based on advice from the Mental Health and Addictions Steering Committee and data analysis.

Resource Matching and Referral (RMR) is the second intervention to create a coordinated point of access. This is an electronic system will allow health service providers to identify the most appropriate and first available service to meet the client’s needs. It will reduce process inefficiencies and allow the LHIN to identify service gaps, leading to better planning and resource allocation.

Capacity. The LHIN will increase service capacity in the areas of highest need – supportive housing for clients living with mental illness and/or dementia, outreach teams and crisis intervention to enable clients to remain in the community and their homes, and services to transition post-acute clients from hospitals and into community care.

Shared Clinical Information. Expanded access to Electronic Medical Records (EMR) for homeless clients. This will give more providers who care for homeless population’s access to clients’ clinical information and enhance clinical decision-making.

These interventions will contribute to the achievement of the goals of reducing emergency room visits and length-of-stay in hospital for patients with mental illness and/or addictions. (See Appendix C or more detail on mental illness and addictions interventions and indicators for these interventions.)

Potential Performance Measures:

Goals	Potential Indicators	Potential Data Sources	Date to Establish Target
Reduce proportion of ED visits where main diagnosis is mental illness and/or addictions	Decreased percent of ED visits in Toronto Central LHIN Acute hospitals where primary diagnosis is mental illness and/or addictions	Canadian Institute for Health Information (CIHI)* (Annual release; Release date: Q3; Data date: previous fiscal year.) EDRS* (Release date: every month; Data date: four months old)	Target to be established by Q4 2009/10
Reduce length-of-stay in hospital for patients with mental illness and/or addictions	Reduced average inpatient length of stay in Toronto Central LHIN Acute hospitals where primary diagnosis is mental illness and/or addictions	CIHI* (Annual release; Release date: Q3; Data date: previous fiscal year.)	Target to be established by Q4 2009/10

* Raw data are available however analysis will need to be provided by Toronto Central LHIN since the LHIN indicators are not currently calculated by CIHI or Access to Care (ATC).

2.2 Reduce escalation of acuity of people with diabetes

Goal

Reduce the rate of diabetes-related complications.

Approach

The Ministry has selected Toronto Central LHIN to play a lead role in the province's Diabetes Strategy, specifically in the development of a diabetes registry and expansion of team-based care.

Progress to Date

The LHIN is establishing a multi-disciplinary and multi-sectoral Diabetes Strategy Steering Committee to guide implementation of a local model for team-based diabetes care. The co-chairs are:

- Dr. Bernard Zinman, Director, Leadership Sinai Centre for Diabetes, Mount Sinai Hospital.
- Lynne Raskin, Executive Director, South Riverdale Community Health Centre.
- Dr. Lynn Wilson, Professor and Chair, Department of Family and Community Medicine, University of Toronto.

The Committee's mandate is to advise the LHIN on how to best implement the team-based care model, performance measures and a performance management system to ensure results are delivered.

The Toronto Central LHIN CEO sits on the Board of e-Health Ontario, giving the LHIN direct insight and input into the diabetes registry and other e-health initiatives.

Interventions

In addition to the initiatives funded or underway, the following interventions are planned or awaiting formal approval:

Team-based care. This initiative aims to use a “hub and spoke” model to transform the patchwork of diabetes services into a coordinated local network of diabetes providers. Existing providers in the LHIN will be designated as hubs, and will be linked with the range of local providers, creating a local diabetes care system.

Complex care case management. Additional case management teams will be in place to manage high-needs clients.

Diabetes Registry. During the timeframe of the Roadmap, the provincial Diabetes Registry will begin to provide people with diabetes and their providers with access to a comprehensive electronic diabetes record that will track outcomes and provide educational tools to better manage care.

Diabetes outreach/education program. This investment will expand an existing diabetes education centre to offer ethnocultural tools and services to specific populations (i.e. South Asians and/or Aboriginals) living in priority neighbourhoods to support early detection and management of diabetes.

As a result of these interventions, more high risk and under-served populations will receive care, and more people with diabetes will be managed according to best practice guidelines. (See Appendix D for more detail on diabetes interventions and indicators for these interventions.)

Potential Performance Measures

Goals	Potential Indicators	Potential Data Sources	Date to Establish Target
Reduce the rate of diabetes-related complications	Decreased percent of ED visits in Toronto Central LHIN Acute hospitals where main diagnosis is diabetes (a-hyperglycemia, b-hypoglycemia)	CIHI, NACRS* (<i>Annual release: Release date: Q3; Data date: previous fiscal year</i>)	Targets to be established by Q3 2010/11
	Decreased percent of inpatient separations from Toronto Central LHIN Acute hospitals where main diagnosis is diabetes complication (a-hyperglycemia, b-hypoglycemia, c-skin/soft tissue infections)		

* Raw data are available however analysis will need to be provided by Toronto Central LHIN since the LHIN indicators are not currently calculated by CIHI or ATC.

2.3 Health system performance

Goal

Meet targets in the Ministry LHIN Accountability Agreement (MLAA) and other accountability agreements.

Approach

The Toronto Central LHIN has developed a robust performance management program to enable the LHIN to meet its accountabilities and achieve outcomes in the MLAA and other performance agreements such as the Emergency Room Pay for Results Program. The LHIN is:

- Developing appropriate performance indicators and targets.
- Developing a process to collect, analyze and use data to manage performance.
- Monitoring performance and taking action to ensure that goals and outcomes are being achieved.

Progress to Date

The Toronto Central LHIN’s performance management program has three main mechanisms:

1. A quarterly management scorecard to monitor performance of MLAA performance indicators among HSPs.
2. A Clinical Service Lead Team (CSLT) comprised of recognized clinical leaders within the LHIN (e.g., the Emergency Department and Critical Care Leads) to review quarterly scorecard for face validity and congruence with field and clinical experience, and to assist with interpretation of results. The CSLT members will also serve as champions for performance improvement with their peers and organizations.
3. Based on the CSLT’s advice, execute appropriate and targeted corrective action with health service providers.

Interventions

The following interventions will improve performance and ultimately result in wait time reductions in local hospitals.

1. ***Execute robust performance reporting and management program.*** The Toronto Central LHIN will further develop and use the performance scorecard, monitor the performance of HSP-led projects, increasingly address performance variances and issues, and take corrective action.

The LHIN will work with the Ministry to improve the quality of MLAA indicators by ensuring there is a clear plan and incentives to enable indicators to produce improvements, that there is a reliable and informative data collection system in place, and that individual organizations can be held accountable for specific indicators.

2. ***Management of Emergency Room – Pay for Results performance.*** The LHIN will monitor and manage the reduction of length of stays in ERs of seven hospitals through regular progress reports and targeted corrective action when hospitals do not meet targets and timelines.
3. ***Ageing at Home (AAH).*** The LHIN will continue to invest AAH funding for interventions designed to reduce ALC days.
4. ***Community and Long-Term Care Accountability Agreements.*** The LHIN will establish the first round of accountability agreements with community providers (M-SAAs) and long-term care providers (LTC-SAAs). It will structure these provider agreements so that they help achieve indicators in MLAA and other LHIN accountability agreements.
5. ***The LHIN has also been selected by the Ministry to lead a GTA-wide project to improve clinical information and exchange across the health care system.*** The GTA Health Information Access Layer (HIAL) project links various information systems such as registries, drug information and lab results to allow the sharing of patient information among care providers.

(See Appendix E for more detail on health system performance interventions and indicators for these interventions.)

Potential Performance Measures

Goals	Potential Indicators	Potential Data Sources	Date to Establish Target
Meet our health system performance goals, as described in MLAA and other accountability agreements (in particular reducing ALC and Emergency Room Wait Times)	MLAA Wait Times Indicators (as listed in Section 4.c)	Access to Care (ATC)	Targets established; to be revised May 2009.
	MLAA System Integration Indicators (as listed in Section 4.c)	Ministry of Health and Long-Term Care	Targets established; to be revised May 2009.
	H-SAA Volume Targets and Performance Indicators (as listed in Section 4.c)	Ministry of Health and Long-Term Care	Targets established; to be revised May 2010.
	M-SAA Performance Indicators (as listed in Section 4.c)	Ministry of Health and Long-Term Care	Targets to be established by March 2009.
	Emergency Department Pay for Performance Targets (as listed in Section 4.c)	Access to Care (ATC)	Targets established; may be revised in 2009/10
Measure to improve client satisfaction	Pending Ministry direction		

* Raw data are available however analysis will need to be provided by Toronto Central LHIN since the LHIN indicators are not currently calculated by CIHI or ATC.

3) Other LHIN Commitments

3.1 Integrated Health Service Plan (IHSP)

Aligning remaining IHSP deliverables, equity emphasis and provincial priorities

The Toronto Central LHIN's 2007-2010 IHSP outlined a series of activities related to nine priorities. While the Roadmap addresses many IHSP objectives, there are some specific IHSP actions that are not directly related to the Roadmap priorities. The majority of these actions have been completed and remaining actions will be completed as follows:

- **Rehabilitation:** Develop and promote the use of standard rehabilitation definitions and evaluate service delivery models.
- **Seniors:** Evaluate impact of work to date and use the Aging at Home Steering Committee as the key mechanism for receiving input from seniors, their families, caregivers and providers, supplemented by other engagement activities targeting seniors.

The LHIN will be conducting its IHSP refresh in 2009, which may modify the actions and implementation approach set out in the Roadmap.

3.2 Health Equity

The goal of promoting health equity informs all of the Toronto Central LHIN's work. The LHIN is taking action in the three key areas identified in the Health Equity Discussion Paper prepared by Bob Gardner of the Wellesley Institute: 1) building equity into service provision, 2) targeting investments and interventions for greatest impact on equity, and 3) embedding equity into our interventions to change the health care system in the LHIN.

The choice to focus on improving access to mental illness and/or addictions, and diabetes care will have a substantial impact on marginalized and under-serviced populations who are severely and disproportionately affected by these conditions.

To obtain baseline information on health equity efforts in the LHIN and to strengthen HSPs' accountability for reducing inequities in their workplace and in care delivery, the LHIN will ask hospitals, for the first time, to submit health equity plans. These plans will inform the next IHSP and will be incorporated into the 2009/10 H-SAAs. The LHIN plans to use a similar approach with community health service providers based on learning from the hospital health equity plans.

3.3 Provincial Priorities

The Toronto Central LHIN is addressing the provincial agenda to reduce ER wait times and rates of alternate level of care (ALC) through mental illness and/or addictions interventions and through participation in the provincial diabetes strategy. At the same time, it is recognized that provincial priorities may be introduced that fall outside the Roadmap's scope and require action by the LHIN. Wherever possible, the LHIN will align provincial priorities with Roadmap goals and interventions.

4) Enabling the Strategic Priorities

4.1 Engaging our Community

The Toronto Central LHIN's community engagement tactics will drive implementation of the Roadmap priorities. They are based on evidence and best practices, designed to promote equity and reflect diversity, and underpinned by a proactive communications strategy.

a) Promoting Equity.

Informed by Bob Gardner's Health Equity Discussion Paper, Seniors Voices on Aging at Home Strategy, and the Healthy Connections conference proceedings, the Toronto Central LHIN will increasingly use community engagement to reduce health inequities.

The LHIN is using innovative and customized tactics to reach under-served and marginalized communities. For example, the Aging at Home (AAH) consultations employed a "local community animation" model whereby local seniors were trained and provided with tools to hold sessions with existing seniors groups in their first language. Sessions were held in English, French, Mandarin, Somali, Spanish, Italian, Portuguese, Tamil, Korean, Farsi, and Bengali and the LHIN provided transportation to further increase access to the consultations. The LHIN has received extremely positive feedback on this approach and the Mississauga Halton LHIN has adopted this community engagement methodology for its AAH program.

As well, the LHIN will increasingly use proven methodologies, such as diversity matrices, to promote equity for its committees and other engagement processes. The LHIN will build a robust contact management database to better target our messaging and connect with a diversity of communities.

b) Restructuring the Toronto Central LHIN's advisory bodies to support implementation

The Toronto Central LHIN has modified its advisory structures to accelerate implementation. For the strategic priorities, the LHIN has shifted from a Council model to Steering Committees that will be made up of individuals who will advise the LHIN on implementation. The LHIN's advisory structures will be decision-focused, time-limited and integrated as needed, and consumer input on Steering Committees will be strengthened. The other IHSP Councils will wind down and established providers and groups will be tasked with implementing activities started by the Councils.

Original Council	New Steering Committees
Mental Health and Addictions Council	Mental Health and Addictions Steering Committee
Seniors Council	Aging at Home Steering Committee
Rehabilitation Council	GTA Rehabilitation Network to serve as a strategic advisory body to the LHIN
	Diabetes Steering Committee
Health Human Resources Council	Health Professionals Advisory Committee (HPAC)
Education and Research Council	Education component to be integrated into HPAC; research component to be integrated into all advisory structures
Energy and Environment Management Council	Non-LHIN led Steering Committee supported by a grant received from Ontario Power Authority
Back Office Integration Council	Non-LHIN led structure of system champions to provide strategic advice to the LHIN
e-Health Council	Toronto Central and Central Joint E-Health Steering Committee

Current consumer and family advisory panels will remain in effect for the duration of the current IHSP. The LHIN is improving the panels based on members' feedback and experience to date. For example, there will be fewer, but longer and more substantive meetings focused on implementation and knowledge transfer. In addition, the panels will be asked to assist the LHIN to tap into established consumer and family groups and networks to further the LHIN's reach and reduce duplication.

c) Increasing the effectiveness and efficiency of community engagement.

The LHIN's community engagement approach will be strengthened and standardized through:

- Board to Board and CEO to CEO engagement.
- Strategic partnerships with NGOs/patient groups/charities, MPPs, Toronto Public Health/City of Toronto, health care associations.
- Engagement with Aboriginal and French Language communities.
- Use of web technologies, including social networking tools.
- Building capacity of HSPs and consumer groups to engage each other to promote cross-sectoral innovations, solutions and integration.
- Engaging HSPs that are not funded by the LHIN, including primary care practitioners.

The LHIN will evaluate and continually improve performance of community engagement through the use of a common assessment tool for all LHINs developed by Dr. Julia Abelson, Associate Professor in the Department of Clinical Epidemiology and Biostatistics at McMaster University.

4.2 e-Health

Approach

The LHIN will align e-health efforts to achieve the patient-centred goals described in this Roadmap. Further recognizing the strong referral patterns that exist among neighbouring LHINs and the necessity of having permeable boundaries for patients, the Toronto Central and Central LHINs have created a Joint e-Health Strategy to integrate e-health initiatives in our respective LHINs.

Progress to Date

In 2009/10, the Toronto Central LHIN expanded its Resource Matching and Referral Program to focus on matching referrals to long-term care. This initiative will assist in meeting the MLAA indicators such as reduced ALC days and median time to long-term care placement. In addition, the Ministry has asked the Toronto Central LHIN to lead the GTA Health Information Access Layer (HIAL) project, which will result in a single, integrated clinical information system for providers across the LHIN.

Interventions

Improving the care process through Resource Matching and Referral. The Toronto Central LHIN Resource Matching and Referral Program involves the implementation of an electronic referral system that matches patients to the most appropriate care based on their needs, increasing equity and transparency, as well as appropriateness of services.

Improve the care process through the use of the provincial Diabetes Registry. In recognition of the at-risk communities in Toronto, the LHIN has been asked to participate in the Ministry-led Diabetes Registry, which will be used to identify and attach patients to appropriate health service providers to support management of persons with diabetes.

Improve the ability to exchange information across the health system. Through the secure exchange of information between providers, the GTA HIAL and Provider Portal will play a critical role in enabling the LHIN to deliver on its strategic priorities. Ultimately, the LHIN will have information to better identify and solve health system issues.

Support implementation of Provincial e-Health Initiatives. For the next three years, the Toronto Central LHIN will continue to participate in other provincially directed or mandated e-Health activities.

4.3 Integration

Integration of health services is a crucial lever for achieving system change. The LHIN has simplified and brought greater rigor to the process by which HSPs notify the LHIN of the intention to voluntarily integrate. This will ensure the LHIN has the necessary information to evaluate integration proposals.

4.4 Transparency

Public reporting of results can be a powerful means to stimulate performance improvement. The LHIN will follow best practices for performance management by first sharing data and information with providers, working with them to improve data quality and moving to public reporting once the data meet an appropriate quality standard.

5) Funding Strategy

The LHIN will maximize the impact of its limited discretionary funding by targeting investments at strategic priorities. In addition, the LHIN will work closely with the Ministry to align objectives and secure additional provincial funding where available.

Investment Strategies:

- 1) ***Seek funding from Ministry for aligned objectives*** – Because of the alignment between the Ministry’s diabetes and e-health strategies and the LHIN’s diabetes and e-health plans, it is anticipated that the bulk of funding for these initiatives, including large e-health projects such as the HIAL, will come from the government.
- 2) ***Targeted use of Urgent Priority Funds (UPF)*** – The LHIN established and presented to the Board Finance and Audit Committee an investment and fund disbursement schedule for Urgent Priorities Fund. This schedule will be followed and where possible, these funds will be used to support the strategic priorities. Since the LHIN anticipates the majority of funding for diabetes will come from the province, the discretionary funds will be dedicated to mental illness and/or addictions.
- 3) ***Targeted use of Aging at Home (AAH) Funds*** – The Aging at Home strategy is supported by base funding. The LHIN will give priority to interventions that assist seniors with mental illness and/or addictions and have the potential to reduce ALC days or ER wait times.
- 4) ***Targeted use of Emergency Room Pay for Results Dollars*** – In 2008/09, the Ministry provided seven Toronto Central LHIN hospitals with funding to reduce ER wait times. Although not announced, it is anticipated that the Ministry will continue to invest in this initiative. The LHIN will work with the hospitals to ensure that a portion of the funds are targeted at reducing ER visits and wait times for people with mental illness and/or addictions.
- 5) ***Application for funds through the Annual Service Plan process*** – On an annual basis, LHINs submit an Annual Service Plan (ASP). In the 2009/10 ASP, Toronto Central LHIN requested for funding for mental health, addictions and diabetes. In past years, the ASP has not been a significant source of revenue for the LHIN.
- 6) ***Use of in year recoveries*** – These funds typically become available at the end of Q3. 50% of these funds could be directed to mental illness, addictions and diabetes. These one-time funds are best for short-term needs, i.e., infrastructure.

6) Risk Management

There are four key risks to executing the Roadmap successfully. The LHIN has reviewed risks a) and c) with the Board through the Annual Service Plan and Quarterly submissions.

- a) ***Fiscal Outlook*** – For planning purposes, the LHIN assumes the instructions from the Ministry after the government’s Q2 financial statement will hold, specifically: base budget out-year planning targets will be protected and that the provincial diabetes program will continue as planned. The LHIN has assumed no targeted provincial funding for mental illness and/or addictions. However, it is well recognized that the fiscal outlook is unclear at this time, and any significant change in the financial status of the Ministry or LHIN’s HSPs will affect the ability to implement Roadmap activities. The LHIN has initiated a mitigation strategy including working closely with Ministry to monitor revenue assumptions, and empowering Back Office Integration Council co-chairs to lead process to broadly examine non-clinical integration opportunities.
- b) ***Alignment of Accountability*** – To drive change, clear lines of accountability from the Ministry to the LHIN and the LHIN to its HSPs are required. Some of the current MLAA indicators do not have clear lines of accountability.

Mitigation Strategy – The LHIN will work with the Ministry to improve indicators included in the MLAA.

- c) ***Measurement*** – There are challenges in measuring the goals listed in the Roadmap. First, system outcomes for many interventions will not be achieved within timeframe of Roadmap. For example, it takes several years of well-managed patient-care to reduce diabetes-related complications. Second, accurate measurement systems do not always exist. In some cases, the baseline data will already have been influenced by LHIN initiatives that are underway and therefore do not reflect a true baseline upon which to measure progress. Finally, given the substantial time lag for receiving data, they do not always reflect recent performance.

Mitigation Strategy – To address the issues above, the LHIN is identifying interim outcomes toward which it is working, in order to reflect progress within a shorter time period. Additionally, the LHIN is working to identify data sources that provide more recent data to minimize the impact of the time lag mentioned above.

APPENDIX A – Targets and Measurement

The LHIN will work with experts to refine the following indicators, create systems to collect data and monitor progress, and establish targets.

Goals	Potential Indicators	Potential Data Sources	Date to Establish Target
Reduce proportion of ER visits where main diagnosis is mental illness and/or addictions	Decreased % of ER visits in Toronto Central LHIN acute hospitals where primary diagnosis is mental illness and/or addictions	Canadian Institute for Health Information (CIHI)* <i>(Annual release; Release date: Q3; Data date: previous fiscal year.)</i> EDRS* <i>(Release date: monthly; Data date: 4 months old)</i>	Target established by Q4 2009/10
Reduce length-of-stay in hospital for patients with mental illness and/or addictions	Reduced average inpatient length of stay in Toronto Central LHIN acute hospitals where primary diagnosis is mental illness and/or addictions	CIHI* <i>(Annual release; Release date: Q3; Data date: previous fiscal year.)</i>	Target established by Q4 2009/10
Reduce the rate of diabetes-related complications	Decreased % of ER visits in Toronto Central LHIN Acute hospitals where main diagnosis is diabetes (a-hyperglycemia, b-hypoglycemia)	CIHI, NACRS* <i>(Annual release; Release date: Q3; Data date: previous fiscal year)</i>	Targets established by Q3 2010/11
	Decreased % of inpatient separations from Toronto Central LHIN Acute hospitals where main diagnosis is diabetes complication (a-hyperglycemia, b-hypoglycemia, c-skin/soft tissue infections)		
Meet our health system performance goals, as described in MLAA and other accountability agreements (in particular reducing ALC	MLAA Wait Times Indicators	Access to Care	Targets established; revise May 2009.
	MLAA System Integration Indicators	Ministry of Health and Long Term Care	Targets established; revise May 2009.
	H-SAA Volume Targets and Performance Indicators	Ministry of Health and Long Term Care	Targets established; revise May 2010.

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Goals	Potential Indicators	Potential Data Sources	Date to Establish Target
reducing ALC and Emergency Department Wait Times)	M-SAA Performance Indicators	Ministry of Health and Long Term Care	Targets established by March 2009.
	Emergency Department Pay for Results Target	Access to Care (ATC)	Targets established; may revise in 2009/10
Measure to improve client satisfaction	Pending Ministry direction		

* Raw data are available however analysis will need to be provided by Toronto Central LHIN since the LHIN indicators are not currently calculated by CIHI or ATC.

APPENDIX B – Glossary

ACRONYMS	MEANINGS
A1C	Glycated Hemoglobin or HbA1c
AAH	Aging at Home
ALC	Alternate Level of Care
ASP	Annual Service Plan
ATC	Access to Care
CAISI	Client Access to Integrated Services and Information
CAMH	Centre for Addiction and Mental Health
CEO	Chief Executive Officer
CIHI	Canadian Institute for Health Information
CSLT	Clinical Services Leadership Team
EDRS	Emergency Department Reporting System
EMR	Electronic Medical Record
ER	Emergency Room
GTA	Greater Toronto Area
HIAL	Health Integration Access Layer
HPAC	Health Professionals Advisory Committee
H-SAA	Health Service Accountability Agreement
HSP	Health Service Provider
IHSP	Integrated Health Services Plan
LHIN	Local Health Integration Network
MLAA	Ministry LHIN Accountability Agreement
M-SAA	Multi-sector Service Accountability Agreement
MPP	Member of Provincial Parliament
NACRS	National Ambulatory Care Reporting System
PCO	Project Coordination Office
RMR	Resource Matching and Referral
UPF	Urgent Priorities Fund

APPENDIX C – Mental Illness and/or Addictions Interventions

Intervention	Description	Timeline	Deliverables and Results	Potential Indicators
<p>Coordinated Point of Access</p> <ul style="list-style-type: none"> - Standard Processes (Intake and Assessment) - Resource Matching and referral Implementation 	<p>Develop standard processes and facilitate use of these tools electronically. The supportive housing sector has been identified as an initial area of focus. Based on advice from the Council as well as analysis of data, the next subset of the mental illness sector will be identified for which to create a coordinated point of access.</p>	<p>Q4 2009/10</p> <p>Q2 2010/11</p>	<p>Standard process(es) established for Supportive Housing</p> <p>Standard process(es) established for specific service(s)</p> <p>Transparent & consistent means to access the most appropriate services/programs</p>	<p>Percent of persons with mental illness and addictions referred through standard process (Resource Matching and Referral (RMR), HSP reporting)</p>
<p>Capacity:</p> <ul style="list-style-type: none"> - Supportive Housing - Outreach Services - Transitional units 	<p>Increase capacity in a number of service areas, where existing evidence shows demand for services is greatest. Focus:</p> <ul style="list-style-type: none"> - services that assist consumers to remain in the community - supportive Housing for clients living with mental illness and/or dementia - services that help to meet increased and changing needs of consumers, such as providing assessments in the community - psychogeriatric outreach teams, St. James Town Outreach Program, Crisis intervention for those living with mental illness and/or 	<p>Q4 2009/10</p>	<p>Additional supportive housing units available</p> <p>Access to additional specialized services</p>	<p>Volume of patients who access supportive housing</p> <p>Volume of patients who access beds in transitional units</p> <p>Volume of patients who access outreach services (HSP reporting, RMR)</p>

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Intervention	Description	Timeline	Deliverables and Results	Potential Indicators
	addictions services to help transition consumers out of hospitals when acute care services are no longer required - high support model at John Gibson House to move long term psychogeriatric patients from CAMH and from acute ALC			
Shared Clinical Information - Expansion of EMR for homeless clients	Monitor expansion	Q1 2009/10	Additional providers servicing homeless population have access to client's clinical information	Volume of agencies where providers can access clinical records of homeless population (CAISI)

APPENDIX D – Diabetes Interventions

Intervention	Description	Timeline	Deliverables and Results	Potential Indicator
Team based care	<p>Increase the capacity of services by creating a diabetes network and hub & spoke model of care, expanding satellite teams in areas of most need in the LHIN.</p> <p><u>Q4 2008-09:</u> Assess current state of services, identify criteria and methodology to determine which providers will take on role of hubs; identify strategies for integrating existing specialists into diabetes network.</p> <p><u>2009-10:</u> Identify locations of hubs of care and satellites; identify best practices of care, identify indicators tools to measure success. Implement expansion.</p> <p><u>2010-2011:</u> Monitor and measure success to further expand model</p>	Q4 2009/10	<p>Diabetes Network launched</p> <p>Best practice guidelines set</p> <p>High-risk/under-served people with diabetes will have access to care</p>	Percent of persons with diabetes being managed according to Canadian Diabetes Association guidelines (i.e. receive the following: a) A1C in the last six months; b) feet exam in the last year; c) eye exam in the last year; d) cholesterol checked in the last year; e) all four services received in the last year). (Diabetes Registry, HSP reporting)
Complex care case management	<p>Implement additional intensive case management teams to manage clients with diabetes-related complications who have had more than one hospital visit.</p>	Q4 2009/10	<p>People with diabetes begin to be identified</p> <p>High-risk/under-served people with diabetes will have access to care</p>	See above
Diabetes Registry	<p>Enter people with diabetes into an electronic registry which will provide them and their providers with instant access to electronic information and educational tools to better manage care. The Ministry has fully defined the details of the Diabetes Registry and its</p>	<p>Q3 2009/10 people with diabetes identified</p> <p>Q3 2010/2011</p>	<p>Comprehensive electronic clinical record in place for people with diabetes</p>	<p>Volume of persons with diabetes identified (registry, manual process)</p> <p>Percent of identified</p>

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Intervention	Description	Timeline	Deliverables and Results	Potential Indicator
	<p>implementation.</p> <p><u>Q4 2008/2009:</u> Determine the scope and pre-implementation plan for the Diabetes Registry e-Health Special Project.</p> <p><u>2009/2010:</u> The e-Health Special Project likely will be implemented by end of Q2 and roll-out of the Diabetes Registry will begin in Q3.</p> <p><u>2010/11:</u> Continued implementation of Registry. Implementation will be phased at many levels including functionality, reach (organizations involved), etc.</p>	<p>Providers have access to clients' clinical info</p>		<p>people of diabetes attached to a primary care provider (registry, manual process)</p> <p>Percent of identified people being tracked in electronic registry (registry)</p>
<p>Diabetes outreach/ education program expansion</p>	<p>Expansion of an existing diabetes education centre to offer ethnocultural tools and services to at-risk populations, i.e. South Asians and Aboriginals living in priority neighborhoods, to support early detection and appropriate management of diabetes. Outreach will occur at places of worship, management plans will be designed with a South Asian diet focus</p>	<p>Q4 2008/09</p>	<p>Better education for management of diabetes for at-risk populations, i.e. South Asians and Aboriginals</p>	<p>Volume of people with diabetes who access diabetes education (HSP reporting)</p>

APPENDIX E – Health System Performance Interventions

Intervention	Description	Timeline	Deliverables and Results	Indicators
<p>Internal efforts to improve performance reporting and management</p>	<p>The TC LHIN Senior Management Team will continue to refine and improve its quarterly reporting process. In addition, the LHIN established a Project Coordination function to consistently monitor progress of projects led by HSPs and take action where required.</p>	<p>Quarterly; ongoing</p>	<p>Quarterly Scorecard Reporting demonstrating: - High Quality, Actionable Information - Performance Trending in the Right Direction</p>	<p>90th Percentile Wait Time for Cancer Surgery, Cardiac Bypass Surgery, Cataract Surgery, Hip and Knee Surgery MRI and CT Scans; Readmission Rate for Acute Myocardial Infarction; Rate of Emergency Visits that Could be Managed Elsewhere; Hospitalization Rate for Ambulatory Care Sensitive Conditions; Percent of Alternative Level of Care Days; Median Wait Time to Long Term Care Home Placement</p>
<p>Management of ER/ALC- Pay For Results performance</p>	<p>The LHIN is accountable for monitoring reduction of length of stay in ER at seven hospitals. Key steps are being followed to ensure performance: - Monitoring results through progress reports submitted to the LHIN - Ad hoc corrective action taken if performance varies from expected outputs or timelines.</p>	<p>2008/09</p>	<p>ER Wait Time Reduction demonstrated</p>	<p>Reduce ER Length of Stay</p>

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Intervention	Description	Timeline	Deliverables and Results	Indicators
<p>External efforts to improve performance reporting</p>	<p>Work with the Ministry to define future MLAA indicators that satisfy the following criteria:</p> <ul style="list-style-type: none"> - Clear plan and incentives to ensure improvements can result from measuring the indicator - Identifiable system for data collection that is reliable and informative - Indicators that can be mapped to specific organizations <p>Work with HSPs to create agreement schedules to align with MLAA indicators:</p> <ul style="list-style-type: none"> - Negotiate M-SAA schedules to align with MLAA indicators (Q3 2008/09; Q3 2010/11) - Negotiate H-SAA schedules to align with M-LAA indicators (Q3 2009/10) - Negotiate LTC SAA schedules to align with M-LAA indicators (Q3 2009/10) 	<p>Q4 annually</p>	<p>Quarterly Scorecard Reporting demonstrating:</p> <ul style="list-style-type: none"> - High quality, actionable information - Performance trending in the right direction 	<p>Same indicators listed under Internal efforts to improve performance reporting and management</p>