Mississauga Halton **LHIN**

Mississauga Halton
Local Health Integration Network

Annual Business Plan

April 1, 2012 – March 31, 2013

Ontario
Local Health Integration Network

Ms. Rachel Kampus
Acting Assistant Deputy Minister, Health System Accountability and Performance Division
Hepburn Block, 5th Floor
80 Grosvenor St.
Toronto ON M7A 1R3

June 7, 2012

Dear Ms. Kampus:

On behalf of the Mississauga Halton LHIN Board, it is my pleasure to submit to you our Annual Business Plan (ABP) for 2012/13.

This plan outlines how initiatives will be executed and delivered by the Mississauga Halton LHIN to implement Year 3 priorities of our Integrated Health Service Plan and Ministry priorities as noted in the ABP development template. This plan is a solid foundation for the work to come and builds on the successes achieved in our past business plans.

The Mississauga Halton LHIN ABP reflects the current local reality in our LHIN and takes a focused set of actions to achieve the Mississauga Halton LHIN's priorities. It further recognizes the health care direction articulated by the Ministry of Health and Long-Term Care related to reducing wait times in emergency departments, reducing the amount of time patients spend in alternate level of care beds, improving access to integrated diabetes care and integrating mental health and addictions services to better serve patients' needs. Within each priority, the LHIN seeks to focus on quality and a shift from institutional care to community-based care.

We are looking forward to continued collaboration with health service providers, communities within the LHIN, the Ministry and other LHINs to deliver on our ABP to the over 1 million people we serve.

Sincerely,

Bill MacLeod
Mississauga Halton LHIN
Chief Executive Officer

Mississauga Halton
Local Health Integration Network

Annual Business Plan
2012/13

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2.0 CONTEXT

The Ministry of Health and Long-Term Care's (MOHLTC) vision is:
"A health care system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren."

In January of 2012, the Minister of Health announced Ontario's Action Plan for Health and noted three key priorities:

- Keeping Ontario Healthy
- Faster Access to Stronger Family Health Care
- Right Care, Right Time, Right Place

It is clear that our growing, aging population and the fiscal environment that we live in requires changes to how health care is delivered. In alignment with the overarching provincial vision, the Mississauga Halton (MH) LHIN Annual Business Plan (ABP) articulates a plan to operationalize the provincial strategy at a local level for the upcoming year 2012/13 and build a quality, evidence-based, patient centred health system that is responsive to the needs of the community.

2.1.2 Mandate

The MH LHIN includes the communities of South Etobicoke, Oakville, Halton Hills, Milton and most of the City of Mississauga. Serving a population of approximately 1.1 million residents, the MH LHIN is focused on transforming the provision of health care services in order to achieve our vision of "a seamless health system for our communities – promoting optimal health and delivering high-quality care when and where needed."

Supporting and promoting integration as a catalyst for positive change in our local health care system, the MH LHIN is committed to working collaboratively with our health service providers and other partners and community members to achieve the priorities identified provincially and within our Integrated Health Service Plan (IHSP). Through active partnerships with health service providers that are funded by the LHIN as well as other non-LHIN funded health care partners (including, but not limited to physicians, public health departments, social service agencies and others), the MH LHIN has developed a solid plan for the upcoming year to achieve its identified goals and objectives at a local level and contribute to the MOHLTC's overall health care strategy for Ontarians.

2.1.3 Overview of the MH LHIN's Current and Forthcoming Programs and Activities

The MH LHIN identified six key strategic priorities within its 2010 – 2013 IHSP (refer to Section 3). Over the past two years, the MH LHIN has worked actively with the 75 agencies that it funds (including 33 Community Support Service, 12 Mental Health and Addictions, 1 Community Care Access Centre, 2 Hospitals and 27 Long-Term Care Homes) to develop innovative programs and activities that support identified strategic priorities in a fiscally challenging environment.

All health service providers that receive funding from the MH LHIN are guided by our IHSP. In addition to aligning their organizational goals with the priorities of the LHIN and the province, health service providers are held to the LHIN's values of innovation, integrity, accountability, partnership, respect and a holistic approach to delivering health care services.

Key areas of focus and activity within the MH LHIN over the past two years have been building community capacity to enhance seniors' health and avoid institutionalization, reducing emergency department wait

times, decreasing alternate level of care (ALC) days, improving access to necessary health services when needed, chronic disease prevention and management, creating LHIN-wide regional programs and enhancing mental health and addictions services. Engagement of the local community, with a particular focus on the needs of the Francophone and Aboriginal communities of the LHIN, has been paramount to all program planning and implementation, as well as in the evaluation of programs and services.

The principles of community engagement, cooperation, coordination and integration, equity and diversity, accountability, transparency and sustainability transcend through the activities of the LHIN and its providers. The MH LHIN has worked diligently to develop strong, positive relationships with its health service providers, at both an organizational and governance level. As the LHIN and its providers learn more about the region and the people we serve, we become better equipped to make informed decisions about health system planning and investing in the required services that will meet the needs of our communities.

Building on successes achieved as well as looking to evidence based practices identified across the province and within other jurisdictions, the MH LHIN has imbedded these learnings into the activities and new programs that shape our ABP and align with the provincial priorities for 2012/13. Key areas of focus include:

Advancing a Quality Agenda

The *Excellent Care for All Act, 2010* fosters a focus on the delivery of quality, evidence-based services. The MH LHIN has identified quality as a key priority for 2012/13. Working with Health Quality Ontario (HQO) and its health care providers, the MH LHIN will be actively working to ensure the quality agenda is adopted into the practices of all its providers' activities, supporting an improved quality experience for patients and their families. Further details are outlined in section 3.1 of the ABP, "Improving Access, Quality and Sustainability of the Health System."

Health Equity

A growing body of evidence shows that disadvantaged and marginalized people have both the greatest health care needs and the worst health care outcomes. To achieve a healthier community and an affordable health care system, disparities in access to needed health care services for poor and marginalized individuals must be addressed. Equity is therefore a critical component of quality health care, and the reduction of health inequities will support equal opportunities for health, bring health differentials to the lowest level possible, and help disadvantaged people to attain their full potential. Through adoption of a health equity lens and utilization of the MOHLTC's Health Equity Impact Assessment tool for its programs, the MH LHIN will build improved health equity within its communities and reduce avoidable health disparities between population groups. The MH LHIN will work to assess the primary care needs of marginalized populations and implement engagement strategies to improve relationships across sectors with special emphasis on Aboriginal and Francophone populations.

Building Community Capacity

In adopting a "right care, right place, right person, right time" approach, the health care system is shifting to move people out of institutionalized care and provide services in the community closer to home. In order to build community capacity, the MH LHIN will develop innovative strategies that move beyond simply funding existing community providers and look at other possibilities, such as expanded roles of health care providers, leveraging informal caregivers and engaging those who are closest to community care to identify opportunities for improved efficiencies. The MH LHIN will continue to review and evaluate the success of the Home First approach and associated investments in enhanced community based

services, specialized long-term care supports and transitional services and specialized regional programs to help direct further funding and guide development opportunities.

Enhancing Patient Flow

As patients receive care in a variety of settings and from numerous providers, transition management is a key element to ensuring quality care is received where and when needed. In collaboration with its health service providers, the MH LHIN will identify transition points in a patient's journey and focus on the "transfer of accountability" through the harmonization of processes. Fostering a collaborative, integrated approach to the delivery of health services, enablers to improved patient flow, will be identified and strategies to enhancing transitions will be a priority for the MH LHIN. Key areas of focus will continue to be transition from hospital back to the community and inter-agency coordination.

Program/Service Integration

The MH LHIN has focused integration efforts in a number of key program/service areas over the past few years to enhance quality care provision and create efficiencies. The merger of Trillium Health Centre and The Credit Valley Hospital has created opportunities for enhanced regional program planning and clinical integration. The MH LHIN has initiated regional programming for Maternal, Newborn, Child and Youth and will work with Clinical Leads in these programs to develop integration opportunities that enhance the patient and family experience for residents in our communities.

The integration of Mental Health and Addictions services to improve access and quality of care is also a priority focus for 2012/13. The MH LHIN has also been approved as a pilot site for the Ontario Behavioural Support System Project and Integrated Client Care Project – Palliative Care, two key integration opportunities focusing on improving system integration and enhancing care provision for these client populations. The Enhanced CCAC role is another key priority project for the MH LHIN, supporting coordination and partnering of LHIN-wide agencies for CCAC centralized eligibility processes for referrals to specific services.

The integration work noted above at a local level will be aligned with and guided by provincial strategic directions, including (but not limited to):

- The Mental Health and Addictions Strategy
- The Provincial Rehabilitation and Complex Continuing Care Expert Panel
- The Provincial Behavioural Support System Project
- Strengthening Home Care Services in Ontario Strategy
- The Integrated Client Care Project and Advanced Hospice Palliative Project

2.1.4 Assessment of Issues Facing the MH LHIN (Environmental Scan of Opportunities and Risks)

Health care is a dynamic, changing field. The fiscal constraints facing the province coupled with limited health human resources and an aging, growing, diverse population are key drivers of system change. These challenges must be addressed with innovative strategies that actively move transformation forward.

The MH LHIN will work actively with its health service providers to identify new and innovative approaches to delivering necessary health care services to its residents. Employing an open, transparent, consistent method to priority setting and decision making within the MH LHIN will support achievement and alignment of the desired transformation objectives. Beyond the key priorities noted in section 3.0, the MH LHIN will also be focusing on the following drivers of system change in 2012/13:

Improving Linkages with Primary Care

The MOHLTC's support for a Primary Care Lead within the LHIN is a key enabler to achieving the MH LHIN's goals and objectives for the upcoming year. The MH LHIN will work closely with this new Lead to develop a local Primary Care strategy that will foster engagement of primary care physicians in key program priorities, including emergency department wait times, alternate level of care days, palliative care, mental health and addictions and chronic disease management. In addition to the MH LHIN's existing strategies for improving access (see section 3.1), enhanced collaboration with primary care physicians will further support these initiatives to increase access to health care services for the residents of the MH LHIN.

Alternative Health Care Funding & Spending Methodologies

The current economic environment requires prudent use of financial resources. The MOHLTC is introducing reforms that focus on providing quality services supported by evidence to increase the value of investments in the health care system. The MH LHIN will work closely with its health service providers and the MOHTLC to implement new funding reforms over the upcoming year. A key change for the upcoming year is patient-based funding for hospitals.

Patient-Based Funding For Hospitals

Under the current model, hospitals receive a lump-sum payment for their global budget, which is based on a hospital's previous budget. The new patient-based funding model is based on funding patients rather than lump-sum payments to institutions. There are two main components to patient-based funding:

i. Health-Based Allocation Model (HBAM)

Health-Based Allocation Model is an evidence-based funding method that takes into consideration the population and clinical needs of the communities served by a hospital. Population information includes age, gender and growth projections, as well as socio-economic status and geography. Clinical information measures how many complex patients are receiving care and the types of care being provided to the community. Hospitals that serve growing and more clinically complex communities will see an increase in their funding over time.

ii. Quality-Based Procedures

Health care providers will receive funding for the number of patients they treat for select procedures, using standard rates that are adjusted for each procedure. The provincial government will establish prices for hospital services based on efficiency and best practices.

Starting in April, Quality-Based Procedures will include:

- Hip replacement
- Knee replacement
- Dialysis and other treatments for chronic kidney diseases
- Cataract surgery

Global budgets will still be in place for activities that cannot be modeled. The MH LHIN will work with its health service providers to prepare and educate them on the patient-based funding model, as quality based funding is phased in over a 3 year period to account for 30% of funding allocations by 2014.

3.0 INTEGRATED HEALTH SERVICE PLAN 2010 – 2013 PRIORITIES

3.1 Improving Access, Quality and Sustainability of the Health System
3.2 Create LHIN-wide Regional Programs / Integrating Health Care in the MH LHIN
3.3 Prevention and Management of Chronic Conditions
3.4 Integrating Mental Health and Addictions Services
3.5 Enhancing Seniors' Health, Wellness and Quality of Life
3.6 Strengthening Primary Health Care
3.7 eHealth (enabler)
3.8 French Language Health Services
3.9 Engagement with Aboriginal People

3.1 IMPROVING ACCESS, QUALITY & SUSTAINABILITY OF THE HEALTH SYSTEM

Description

Improving access, quality of care and sustainability of the health system supports the delivery of high quality services to the right person, for the right care, at the right time, in the right place and at the right cost. To achieve this goal, the MH LHIN is focusing on improving care transitions, reducing wait times and enhancing community services. Furthermore, person-centred care will be the focus at the MH LHIN, placing the patient/client and their family at the centre of the planning and delivery process.

Current Status

1. Home First: A concept integrated throughout the hospitals and community level, Home First has been successful in decreasing alternate level of care (ALC) length of stay and the number of patients days in hospitals, diverting individuals from long term care homes (LTCHs) and reducing LTCH wait lists in conjunction with other MH LHIN strategies and programs/initiatives. The Home First concept utilizes a variety of "cornerstone" programs to assist with discharge home. These programs include: (1) CCAC Enhanced Home Care services (Wait at Home Enhanced, Wait @ Home – LTC and Stay at Home); (2) Supports for Daily Living; and (3) Short-Stay Restorative program. The MH LHIN Home First concept was recognized in Dr. Walker's Report "Caring for Our Aging Population and Addressing Alternate Level of Care" as the most important best practice component of ALC reduction. It is based on the philosophy that home is the natural state for individuals and provides the best environment for recuperation and post-acute care, while being a less stressful place to make life decisions or experience a life transition.
2. Interim Long Term Care Home Beds at Trillium Health Centre: The implementation of the new 21 Interim long term care home beds at the McCall site of the Queensway Trillium Health Centre was delayed due to renovation work required to ensure that the setting meets Ministry environmental standards. Opening of the beds occurred in April 2012. Improving access, these beds will provide an interim placement opportunity for hospital patients who are waiting for permanent placement into a LTCH of their choice but cannot return to their home to wait for placement.
3. Specialized Behavioural Support Unit at Sheridan Villa: In September 2010, the Specialized Behavioural Support Unit opened at Sheridan Villa. The unit is the first Specialized Unit as designated under the *Long-Term Care Homes Act, 2007*. Supporting quality care, the unit of 19 beds is a transitional unit providing assessment, treatment and transitional support for people in a LTCH or people waiting to be placed in a LTCH who cannot remain in their current environment due to responsive or aggressive behaviours related to progressive dementia. In the first year of operation a total of 42 individuals were admitted to the unit with 28 transitioning from the unit to date. A total of 19 individuals were admitted from hospital and represent a total of 857 days as ALC to LTC prior to placement in the unit. A formal third party evaluation of the program was completed by PricewaterhouseCoopers which reported on the clinical success of the unit but identified that resident flow through was seriously limited due to the current legislative framework for specialized units. With the implementation of the provincial Behavioural Support Ontario program, work has been undertaken to review admission and discharge processes to ensure that the program supports timely discharge when the person no longer requires the services of the unit and others are waiting for admission. Capacity building in the other LTCHs and addition of resources dedicated to providing behavioral supports has been implemented to enhance the ability of homes to accept people coming from the behavioural unit.
4. LTCH Capacity to Care for High Need Residents: Through the support of a number of initiatives, including the NP STAT program (nurse practitioners providing support for LTCH residents with acute or complex

medical issues), Geriatric mental health outreach teams (supporting residents with behavioural issues in LTCHs) and outreach support from Peel, Halton, Dufferin Acquired Brain Injury Services (PHDABIS), LTCHs have been improving access and quality as they have been able to support individuals with increased and more complex medical needs. The Nurse Practitioner in hospital providing repatriation support to LTCHs has also been able to support the care required for individuals who in the past would have been refused placement due to the extent of their medical support requirements. The nurse practitioner is able to verify the current care needs of the individual and assist the LTCH to identify a care plan for the safe care of the individual within a long term care setting. In the past year, the addition of an NP responsible to support repatriation to LTC for individuals admitted to hospital for acute care has allowed for decreased hospital length of stay for LTC residents and increased capacity of LTCHs to support people with more complex care needs.

5. Health Equity: Further to the Health Equity Plan published in 2010, the MH LHIN has started implementing the Health Equity Impact Assessment Tool. To improve access, quality and sustainability, the approach is to plan and evaluate LHIN wide initiatives through the Health Equity Lens to ensure that the programs developed at the LHIN level in collaboration with the health service providers meet the needs of disadvantaged or vulnerable social groups—such as low income, racial/ethnic minorities, women, Francophones and Aboriginal or other groups. Those who have persistently experienced social disadvantage may systematically experience worse health or greater health risks than more advantaged social groups. The MH LHIN has been involved in the Peel Homelessness Health Network Steering Committee to develop a strategy for the homeless and at-risk population in the Region of Peel. Homeless people have higher health care needs and an increased rate of emergency department visits and repeat visits to hospitals, as they have significant barriers to accessing health care.
6. CCIM - OCAN and RAI CHA: The implementation of these two assessment tools for mental health and community support services has seen a transformational “ripple” effect, particularly in the community support services sector. As an early adopter of the RAI-CHA, the MH LHIN has acquired almost 5 years of experience in the instrument and has witnessed the realization of the power of the information acquired through the tool in the CSS sector. Having information and profiles on clients that is grounded in validity and reliability has enabled the supportive housing program and now the remaining CSS programs to utilize the knowledge to influence service and practice. Use of these assessments has greatly influenced standardization and has had a positive impact on the quality of service delivery. With the introduction of the IAR and Shared Assessment principles, the integration and coordination of care for a client can be better aligned to increase the quality of care as well as decrease repetition and duplication. We are anticipating as the year progresses that greater learnings from the implementation of the IAR, Shared Assessment and assessment tools will see a new clarity of understanding and cooperation amongst all HSPs.
7. Community Support Services and Mental Health and Addiction Agencies Accreditation: The M-SAA with the MH LHIN Community Support Services (CSS) and Mental Health & Addiction (MH&A) Health Service Providers requires that “all HSPs engage with an Accreditation body (provincial or national) with initial accreditation to be completed by September 30, 2013. Once accredited, an HSP is required to maintain accreditation and to inform the LHIN each time accreditation is awarded.” By the end of fiscal 2012/13, 36 community HSPs will have completed their accreditation.
8. Improving Efficiencies in Cataract Surgery within the MH LHIN: The MH LHIN has the longest wait times for cataract surgery of all the LHINs. After an in-depth analysis and meeting with hospital leaders and LHIN Ophthalmologists, there was interest in exploring the development of a dedicated centre for cataracts and/or centralized wait list. The LHIN will engage the hospitals and Ophthalmologists in this fiscal year to develop a business case for this initiative.

9. Capital Expansions in Hospitals: As the MH LHIN population continues to grow at one of the fastest rates of any LHIN in Ontario, hospital capacity must be expanded to meet the healthcare needs of local residents. The following hospital capital expansions are being planned or have been endorsed by the MH LHIN:

   The Credit Valley Hospital and Trillium Health Centre: expanded Operating Room volumes, Emergency Department Visits and ICU volumes through Post Construction Operating Plan (PCOP) funding (CVH site) and renovations / refurbishment of the kitchen and nutrition services (THC – Mississauga);

   Halton Healthcare Services: expanded Diagnostic Imaging and Emergency Department (Georgetown Hospital), new hospital developments (both Milton and Oakville).

   Together, these capital projects will help to ensure that local hospitals have the appropriate capacity to meet the needs of MH LHIN residents.

10. Integrated Discharge Strategy: The integrated discharge strategy is an undertaking the MH LHIN is beginning in 2012. The premise for the strategy is to determine if a single or multiple methodologies can be undertaken for determining discharges from hospital – can we build on best practices already in place from other areas within the province? What do we need to do to improve our current processes? Who should be accountable for discharging? Currently we are progressing with our research and information/data gathering process and plan to be concluded by mid-to late-May. At that time we will determine our plan for leading regional discussion, action and timelines for completion. At this time we are anticipating a potential completion date of 2014 for full integration and sustainability. Indicator development and targets will also be set later in 2012 to measure progress toward completion, full integration and sustainability.

11. Local Application of *Excellent Care for All Act*: Both LHIN hospitals have submitted their Quality Improvement Plans to Health Quality Ontario and the LHIN as required by the *Excellent Care for All Act*. To further imbed quality improvement throughout the MH LHIN, staff support was created by expanding the role of its Governance Lead to include a quality improvement focus.

12. LTC Restore Transitional Program: The Restore program is a 26 bed unit providing increased activation, rehabilitation and restorative services to patients following extended hospital stays who no longer require acute care services but cannot safely return home. The program, which helps patients to regain physical function so that they are able to safely return to their home in the community following prolonged hospital stay, continues to operate at Cooksville Care Centre, a LTCH. Prior to January 2011, Cooksville Care Centre was previously known as the Mississauga Lifecare Centre. This program is transitional in nature with a target length of stay of 42 days. In the past year, 165 people have benefited from the services of the program. The program supports sustainability in the health system, as it supports people to regain physical function required to return to their home in the community, with or without community supports and prevent premature placement into a LTCH.

Goals

Improve access and quality of care for patients/clients and supporting a sustainable health system through:

- Increased community capacity to provide quality service to high needs individuals as an alternative to relying on hospitals or LTCHs
- Increased ability to share information amongst providers to enable more coordinated and aligned care for clients as well as decrease repetition and duplication
- Improve LTCH capacity to serve high needs clients
- Reduced hospital wait times for cataract surgery and MRI services
- Reduced hospital wait times for ED admitted patients

Consistency with Government Priorities
Aligns with government priorities such as the ED/ALC Strategy, Seniors Friendly Hospital Strategy, Ontario Behavioural Support Services Project, Community Care Information Management (CCIM), Mental Health & Addictions Strategic Direction, the *Excellent Care for All Act* and advancing High Quality, High Value Hospice Palliative Care Recommendations.

Action Plans	2012/13		2013/14		2014/15	
	Status	%	Status	%	Status	%
1. Home First - focus on improving 9.2% total ALC in hospital through a variety of methods	Ongoing	25%	Ongoing	25%	Ongoing	25%
2. Enhancing Long Term Care Home Capacity:						
a. 220 new interim beds at Trillium Health Centre	In progress	10%	In progress	25%	Complete	65%
b. Identify future capacity needs for Long Term Care Home Beds and Services	In progress	50%	Complete	50%		
3. Implement Behavioural Support Ontario Project as per Provincial Project	In progress	90%	Complete	10%		
4. ABI Specialization at Extendicare Halton Hills Long Term Care Home	Complete	100%				
5. ECHO – Women's Health Implementation of standards of care by Ontario Network of Sexual Assault & Domestic Violence Treatment Centres	In progress	50%	Complete	50%		
6. Complete CCIM provincial projects:						
a. OCAN and CHA implementation	Complete	100%				
b. Shared Assessment	Starting	50%	Complete	50%		
c. IAR	Complete	100%				
d. RM&R	In Progress	75%	Complete	25%		
7. Further the CSS and MH&A accreditation process and number of agencies fully accredited	In progress	84%	Complete	16%		
8. Improve efficiency and timeliness of Cataract surgery within the MH LHIN	In progress	50%	Complete	50%		
9. Review Capital requirements for hospital infrastructure/bed capacity to	In progress	25%	In progress	25%	In progress	25%

meet local needs and develop Regional Master Program Plan						
10. Integrated Discharge Planning	In progress	50%	Complete	50%		
11. Develop LHIN Vision for Quality	In progress	100%				
12. Evaluation of Programs: Home First, Re-Charge and Palliative	In progress	75%	Complete	25%		

How will we measure success?

Performance indicators, in alignment with the MLPA and Stocktake indicators, are noted below. Performance targets for 2012/13 will be determined by the MOHLTC.

Achieve Performance Targets for Reduction In:	**MLPA Target for 2011/12**
Emergency Department:	
1. Percentage of ALC Days in Hospital (%) [MLPA]	9.21%
2. 90th Percentile ER Length of Stay for Admitted Patients [MLPA]	23.0 hrs
3. 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients [MLPA]	6.7 hrs
4. 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients [MLPA]	3.7 hrs
Surgical and Diagnostic Wait Times:	
5. 90th Percentile Wait Times for Cancer Surgery [MLPA]	57 days
6. 90th Percentile Wait Times for Cardiac By-Pass Procedures [MLPA]	34 days
7. 90th Percentile Wait Times for Diagnostic MRI Scan [MLPA]	97 days
8. 90th Percentile Wait Times for Diagnostic CT Scan [MLPA]	27 days
9. 90th Percentile Wait Times for Cataract Surgery [MLPA]	96 days
10. 90th Percentile Wait Times for Hip Replacement [MLPA]	138 days
11. 90th Percentile Wait Times for Knee Replacement [MLPA]	156 days

These are 2011/12 targets. 2012/13 targets to be negotiated.

Evaluation of Programs: The ability to access programs and sustain them is dependent upon whether those programs are doing what they need to do in order to accomplish the objectives that they were designed to achieve. The MH LHIN is committed to evaluating its programs on a timed schedule (following two years of consistent service delivery). Two programs have been completed (Supports for Daily Living and Restore) and

in 2013, the following programs have a planned schedule for evaluation by a third party source:

a. Home First (scheduled for 2012 – delayed and moved to 2013)

b. Re-Charge (Respite) Program

c. Palliative Initiative – may need to be moved to 2014 dependent upon the Integrated Client Care Project – Palliative provincial timelines

What are the risks / barriers to successful implementation and mitigating strategies?

- Ability to make the transformational shift to community based services within existing resources.
- Community and hospital sector readiness to embrace new ways of completing service, utilizing information in a productive manner and working together for the benefit of clients and system reform.
- Lack of alignment of current legislation and policies to improve care and facilitate timely flow and hand-offs across services.
- Mitigating Strategies: MH LHIN will continue to provide leadership and work closely with the Ministry of Health and Long-Term Care, local health service providers and community partners to promote culture change and transformational system thinking. Opportunities to address gaps and identified barriers will be sought, examined and implemented as appropriate.

What are some of the key enablers that would allow us to achieve our goal?

- Capacity increase (as articulated in Action Plans 2 & 9)
- Partnerships for collaboration
- Implementation of eHealth initiatives
- Process Improvements (LEAN, etc)
- Change management strategies and leadership– active participation by LHIN to effect change and balance perspectives

3.2 INTEGRATING HEALTH CARE IN THE MISSISSAUGA HALTON LHIN (CREATING REGIONAL PROGRAMS)

Description

The MH LHIN mission is "To lead health system integration." The MH LHIN vision is "a seamless health system for our communities by promoting optimal health and delivering high quality care when and where needed." The LHIN's mission and vision have been the basis and guiding force of the LHIN's efforts to improve accessibility, coordination, quality, safety and accountability of services through integration.

Current Status

Integration in the Hospital Sector:

1. Merger of The Credit Valley Hospital and Trillium Health Centre: On April 7, 2011, the Mississauga Halton LHIN received a proposal from the board chairs of the Credit Valley Hospital and the Trillium Health Centre to voluntarily merge the two hospitals into one new corporation. On December 1, 2011 after full consultation with the LHIN and the approval from the Ministry of Health and Long Term Care, Trillium Health Centre merged with The Credit Valley Hospital. On February 1, 2012, the Board Chair of The Credit Valley Hospital and Trillium Health Centre appointed Michelle DiEmanuele as President and CEO of the newly merged hospital.
   Providing the highest quality patient care to the communities of Mississauga, West Toronto and surrounding regions is at the heart of this merger. This merger ensures the most effective allocation of resources for our community by creating one patient experience with interdependent sites. It will provide better access to needed services making it easier for patients to navigate the system enhancing the patient and provider experience. It will provide excellent quality of care enhanced by combining strengths of both organizations. It will improve opportunities for medical students from the Mississauga Academy of Medicine, at the University of Toronto, to be placed in a wide range of health-care settings including the hospital and community service groups. The merger will position them to attract and keep the best doctors, nurses and other health care workers and will allow for better use of resources. This singular governance, leadership, strategy and decision making structure will drive change and deliver results. In 2012/13, MH LHIN will be actively involved with the newly merged The Credit Valley Hospital and Trillium Health Centre, as it considers further integration of programs between sites of this newly merged hospital.
2. Establishment of a Regional Program for Maternal / Newborn / Child / Youth: In 2010/11, the MH LHIN funded a multi-agency committee to develop recommendations for the clinical integration of Regional Maternal Newborn Child Youth Program services. Following approval of these recommendations, a Steering Committee was struck and two clinical leads, one for Maternal/Newborn service and one for Child/Youth services, were identified to champion the program initiatives. The objectives of this committee are to: establish seamless integration to services, improving patient outcomes through equitable access to appropriate care.
3. Transformation and Integration of Hospital Complex Continuing Care (CCC) and Rehabilitation Services: In 2010/11, the MH LHIN undertook a review of the Hospital Complex Continuing Care (CCC) to embed best practices to improve patient outcomes and reduce Average Length of Stay in hospitals. The review was also focused on reducing Alternate Level of Care (ALC). Through the intensive work, the next steps were identified.
4. Establishment of a Cataract Surgery Referral Centre within the MH LHIN: Ophthalmologists, hospital staff and the MH LHIN are interested in exploring the impact of a regional cataract centre on cataract surgery wait times and quality. Once the merger of CVH and THC hospital has settled, the LHIN and hospital

leadership will commence with a work group to develop a business case focused on centralizing cataract surgery in the community.

Integration in the Community Sector:

5. Expanded CCAC Role: In 2010, the MOHLTC extended the legislation for the CCAC for standardized assessment and access in four key areas of services: Adult Day Programs, Supportive Housing, Complex Continuing Care and Institutional Rehabilitation services. The goal of the Enhanced CCAC role is to coordinate the access to these four areas of service through the CCAC, whereas in the past they were either individualized through the provider agency or hospital. Progress has been made in the area of Adult Day Programs as the MH LHIN had access to the programs through the CCAC in place for many years. Business processes have been improved and new methods developed to streamline and "lean out" the process for the Adult Day programs and the CCAC. The supportive housing sector engagement has begun in April of 2012. This engagement was delayed from January due to other CCAC priorities. We anticipate this sector will be completed by early summer as a process is currently in place that functions well for all involved. The CCC and rehab areas will be undertaken beginning in the fall. In MH LHIN, the MH CCAC has completed and submitted a project timeline plan for implementing the full Enhanced CCAC role. The plan is scheduled for completion at the end of fiscal 2013.
6. Palliative Care Initiative: Through the Aging at Home Strategy, the MH LHIN funded a several palliative initiatives aimed at reducing length of stay of palliative patients in acute settings and enhancing home care services to palliative clients and their caregivers in the community in order to enable those clients to die at home if they should desire.
7. Integrated Client Care Project (ICCP) - Palliative: The ICCP is a multi-year initiative developing, implementing and evaluating new and existing models of home care delivery to improve value and quality for the client and the healthcare system, through coordination, integration and specialization. MH LHIN has been participating as one of six pilot sites across the province.

Goals

- Increased community capacity to provide quality service to high need individuals as an alternative to relying on hospitals.
- Streamline access to, and the quality of care of, targeted services within the MH LHIN.
- Maximize capacity across the LHIN.
- Improve use of resources to achieve patient care goals.

Consistency with Government Priorities

Aligns with several Ministry priorities including:

- Aging at Home Strategy
- Maternal/Newborn Access to Care Strategy
- Provincial Expert Panel on Rehabilitation and Complex Continuing Care
- "Strengthening Home Care Services in Ontario 2008" Integrated Client Care Project

Action Plans	2012/13		2013/14		2014/15	
	Status	%	Status	%	Status	%
1. Support Clinical Integration at the Newly Merged Credit Valley Hospital and Trillium Health Centre	Not yet started	25%	In progress	25%	In progress	25%
2. Maternal, Newborn, Child & Youth Regional Program	In progress	20%	In progress	30%	In progress	30%
3. Transformation of Complex Continuing Care and Rehabilitation Services – regional plan	In progress	25%	In progress	25%	Complete	50%
4. Regional Cataract Surgery Centre	Not yet started	25%	In progress	50%	Complete	25%
5. Expanded Role of CCAC	In progress	50%	Complete	50%		
6. Palliative Care Initiative	In progress	50%	Complete	50%		
7. Integrated Client Care Project (ICCP) for Palliative Care	In progress	40%	In progress	40%	Complete	20%

How will we measure success?

1. Achievement by both hospital sites of the best performing standard (targets) for readmissions noted on Page 19.
2. Improvement in Cataract Wait Times MLPA indicator (as noted in section 3.1).

As the action plans for creating regional programs are in the development phase, a key deliverable for this year will be to clearly articulate specific outcome and process measures for the regional programs and initiatives noted above. This will be done at a local level in partnership with health service providers, as well as at a provincial level, whereby provincial working groups (i.e. Advanced Hospice Palliative and ICCP) will be identifying measures of success for all LHINs.

What are the risks / barriers to successful implementation and mitigating strategies?

- Availability of health human resources to implement programs/services.
- Community partners not able to offer suitable space for clinics.
- Readiness and willingness of health service providers to implement regional programs/services.
- Mitigating Strategies: MH LHIN will work closely with the leads for the regional programs to collaborate and collectively address readiness, willingness and change management for successful regional programming. Memorandums of understanding and/or amendments to service accountability agreements will be established (as appropriate) to support accountability of all providers and partners in regional programs.

What are some of the key enablers that would allow us to achieve our goal?

- Capacity Increase
- Partnerships for collaboration
- Health Human Resources
- Engage public about their personal health

3.3 PREVENTION & MANAGEMENT OF CHRONIC CONDITIONS

Description

As our population ages, illnesses such as cardiovascular disease, diabetes and arthritis are becoming more prevalent, and demands for care are rising. To address these needs, the MH LHIN is collaborating on a number of chronic disease prevention and management initiatives aimed at enhancing patients' health and quality of life while reducing costs to the health care system. Clinical case management plays an important role in caring for patients with chronic disease, especially those that may have multiple conditions and a complex range of health and social service needs. Coordinating services across multiple providers and sites will require planning to ensure seamless delivery of care.

Current Status

1. Implementation of the Ontario Diabetes Strategy: Through the Mississauga Halton Diabetes Regional Coordination Centre (DRCC), the Ontario Diabetes Strategy is being executed. The DRCC aims to coordinate the delivery of services within the region through the development of tools such as standardized referral processes, increased awareness of best practices related to diabetes in all diabetes service providers and increasing access to supports required for patients and physicians alike.
2. Chronic Disease Self Management: The Mississauga Halton Self-Management Advisory Committee has been working with the Diabetes Regional Coordinating Centre to further develop, implement and evaluate initiatives pertaining to self-management in the MH LHIN.
3. Community-Based Respiratory Education Program Pilot Project: A proposal was developed and granted funding from PRIISME in 2010/11 to create a Respiratory education program for patients with mild to moderate Chronic Obstructive Pulmonary Disorder (COPD). This program will aim to support both the prevention and management of chronic disease, as well as reduce ED visits. The service provided by the program will also strengthen primary health in terms of providing confirmatory diagnoses enabling the most appropriate treatment for patients.
4. Integrated Regional Approach to Chronic Kidney Disease: A plan for a regional approach to Chronic Kidney Disease was developed in 2010, prior to the development of the Ontario Renal Network (ORN). Many of the priorities identified within the regional plan align with the ORN goals. As a result, the committee will continue to work on the common deliverables. For those deliverables not included in the ORN Plan, the committee is evaluating whether they will continue to be priorities.
5. Ontario Renal Network Provincial Plan: MH LHIN, in collaboration with its health service providers has been providing input on chronic kidney disease system priorities to the Ontario Renal Network. The anticipated launch of the plan is early May 2012.
6. Home Dialysis: Traditional in-centre dialysis requires that patients travel to undergo treatment three times a week in a hospital setting. It is associated with poor patient survival, poor quality of life and high cost. Home dialysis improves the patient's clinical outcomes and quality of life. Within the MH LHIN, home dialysis is offered to patients both in their home and in long term care homes. Supports are available to patients transitioning to this method of treatment from the CCAC.

Goals

- Improve access to integrated diabetes services.
- Improve access to integrated continuum of chronic kidney disease services across the MH LHIN.
- Enhance the self-management supports for individuals with chronic conditions.

Consistency with Government Priorities
Aligns with the province's priority on prevention and management of chronic conditions including: • The Diabetes Strategy • The Ontario Renal Network strategy

Action Plans	2012/13		2013/14		2014/15	
	Status	%	Status	%	Status	%
1. Support Ontario Diabetes Strategy within the MH LHIN through collaboration with the Diabetes Regional Coordination Centre and increased access to coordinated diabetes programs	Complete	50%				
2. Chronic Disease Self Management	Complete	100%				
3. Develop and implement an action plan to provide community-based respiratory education programs	Not yet started	50%	In progress	25%	Complete	25%
4. Develop and implement a local action plan for chronic kidney disease after the provincial renal plan has been released	Not Yet Started	50%	Complete	50%		
5. Collaborate with Ontario Renal Network (ORN) to enhance right access to dialysis modalities	In progress	25%	In progress	25%	In progress	25%
6. Enhance home dialysis and support CVH to implement Grow Home dialysis initiative	Complete	50%				

How will we measure success?

Performance indicators, in alignment with the MLPA and Stocktake indicators, are noted below. Performance targets are subject to change pending negotiations with the Ministry of Health and Long-Term Care. Values indicated below are reflective of fiscal year 2011/12. Readmission indicators do not have targets; rather, there are values for "expected" readmission rates.

Achieve Performance Targets for:	MLPA Target for 2011/12
1. Overall Readmission within 30 Days for 7 Selected CMGs [MLPA]	12.6%
a) Readmission within 30 Days for Pneumonia [Stocktake]	10.60%
b) Readmission within 30 Days for Gastrointestinal [Stocktake]	14.14%
c) Readmission within 30 Days for Cardiovascular [Stocktake]	8.83%
d) Readmission within 30 Days for Congestive Heart Failure [Stocktake]	17.10%

e) Readmission within 30 Days for Chronic Obstructive Pulmonary Disease [Stocktake]	17.20%
f) Readmission within 30 Days for Cerebrovascular Accident [Stocktake]	7.30%
g) Readmission within 30 Days for Diabetes [Stocktake]	5.61%
2. Proportion of primary unilateral Hip or Knee Joint Replacement patients discharged home [Stocktake]	90% +/- 9%
3. Average Length of Stay of primary unilateral Hip or Knee Joint Replacement patients discharged home [Stocktake]	4.4 days

These are 2011/12 targets. 2012/13 targets to be negotiated.

What are the risks / barriers to successful implementation and mitigating strategies?

- Provincial targets for home therapies not reached
- Impacts of initiatives will take time to realize change, and may not be realized in the short-term
- Mitigating Strategies: In collaboration with health system providers and partners, the MH LHIN will closely monitor implementation efforts and focus on measuring performance such that gradual improvements can be identified.

What are some of the key enablers that would allow us to achieve our goal?

- Capacity increase
- Partnerships for collaboration
- Engaged public about their personal health

3.4 INTEGRATING MENTAL HEALTH & ADDICTIONS SERVICES

Description

The MH LHIN currently funds 12 community Mental Health and Addictions agencies across its geographical area to provide services at a local level. The MH LHIN identified this priority to address the challenges facing people living with mental illness and/or addictions and their families in accessing care through a fragmented system. This fragmentation is exacerbated for youth (16-24 years) transitioning from youth to adult Mental Health and Addictions services. One in four families has at least one member with a mental disorder and approximately 20% of the Ontario population will experience a mental health / substance abuse problem at some point during their life. This reduces their quality of life and impacts their health, finances, and relationships. Across the MH LHIN, there is increasing pressure on the current MH&A systems, including both the community and the acute care sector. The number of repeat visits within 30 days to emergency departments for substance abuse issues has been increasing, while repeat visits for mental health issues have been fluctuating up and down. We expect to see increasing pressure as the impact of de-listing the drug Oxycontin works through the system.

Current Status

1. Local Implementation of the Ontario Government's 10 Year Strategy for Mental Health and Addictions: The MH LHIN has considered the provincial guidelines on how to redesign mental health and addictions services to best meet the needs of individuals and how to create the conditions in communities to reach optimal mental health and well-being. As the funding for initiatives to support the strategy rolls out, MH LHIN will collaborate with all the involved stakeholders to ensure effective implementation and the development of key performance metrics.

   Funding Initiatives:

   a. **Mental Health Nurses in District School Boards**: About 70% of mental health problems and illnesses have their onset during childhood or adolescence. Studies suggest that between 15 and 21 percent of Ontario's children and youth have at least one mental health disorder. Schools are on the front lines of dealing with mental health and addictions problems among children and youth. As part of the Ministry's strategy, they are making investments in providing Mental Health Nurses in District Schools. MH LHIN has received funding for 4.5 FTE to support child and adolescents in their schools.
   b. **Telemedicine**: Funding was provided to Trillium Health Centre to fund 3 Nursing FTEs to develop and provide a LHIN-wide program. This program will utilize the Ontario Telemedicine network to reach clients and healthcare providers in the LHIN.
   c. **Early Psychosis Intervention Program (EPI):** The Ministry provided funding for 2 Registered Nurses for the MH LHIN Community Mental Health Early Psychosis Intervention Program. The program reduces the duration of untreated illness for children less than 14 years of age, which improves health outcomes, minimizes disruption to the lives of young people so that their educational, vocational, social and other roles can be maintained and minimizes the societal impact of psychosis. The EPI program keeps children and youth out of hospital and in their communities connected to their families and friends, and in their lives. Research demonstrates the capacity of the EPI program to reduce need for inpatient care by lowering hospital admission rates and the length of stay. This program is a collaborative partnership between HHS, ADAPT, Schizophrenia Society of Ontario, Joseph Brant Hospital and North Halton Mental Health Clinic.
   d. **Eating Disorders:** The Ministry provided funding for 2 Pediatric Nurse Practitioners for Eating Disorders, 1 at the Credit Valley Hospital and the other at Halton Healthcare, to enhance the current Regional Eating Disorder Program.

2. Integration of Mental Health and Addictions Agencies: The 12 Mental Health and Addiction agencies funded by the MH LHIN provide a range of services to people living with mental health and addiction problems. Health Service Providers serve a range of clients, from one HSP who supports 10 clients in a group home to another HSP who provide services to 25,000 individuals. MH LHIN has engaged the mental health & addictions community agencies to explore opportunities for facilitated voluntary integration in order to improve equity, access and quality for the Mississauga Halton LHIN residents.
3. Transitions from Youth to Adult Services: 22 adult and child and youth MH&A health service providers participated in a pilot project "Transitional Aged Youth Protocol" aimed at ensuring transitional aged youth receive seamless care when transitioning from the youth health care system to adult care. The successful pilot resulted in the funding of a full-time regional coordinator on a permanent basis. In addition, the LHIN funded an increase in youth MH&A services with the community based 1.5% funding increase for 2011/12.
4. Community Concurrent Disorders Program (CCDP): After one year of operation, this integrated LHIN-wide program established to reduce emergency department usage by clients with mental health and addictions (concurrent disorders) met its goal by reducing emergency department visits by 1,200 visits. Partners within this program are exploring offering targeted supports to high users of the MH LHIN Emergency Departments.

Goals

- Improve quality as well as equity and access to mental health and addictions services for the residents of the MH LHIN.
- Reduce Emergency Department visits, repeat visits and hospital admissions for mental health and/or addictions by working with Community MH&A supports.
- Increase access to early diagnosis and treatment.

Consistency with Government Priorities

Aligns with the government's Mental Health and Addictions Strategy, with the priorities to promote integration and improve access to mental health and addiction services and act early. Specifically, the identified goals and action plans directly support the government's priorities on Emergency Department service improvement by diverting visits to the ED as individuals will obtain services in the community and the focus on children and youth.

Action Plans	2012/13		2013/14		2014/15	
	Status	%	Status	%	Status	%
1. Work with health service providers to implement the MOHLTC's 10 Year Strategic Plan. Focus will include:	In progress	15%	In progress	25%	In progress	35%
a. Mental Health nurses in schools	Completed	15%				
b. Telemedicine expansion	Completed	15%				
c. Increased capacity for early psychosis intervention	Completed	100%				

d. Increased capacity for eating disorders	Completed	100%				
2. Integration of Mental Health & Addictions Agencies: • Support health service providers who voluntarily wish to integrate • Create / further develop a centralized access program	In progress	25%	In progress	25%	In progress	25%
3. Enhancing Transitional Aged Youth services to minimize service gaps and improve access	Completed	100%				
4. Coordinated Access to Community Mental Health Services (No Wrong Door Approach)	In progress	50%	Complete	50%		

How will we measure success?

Performance indicators, in alignment with the MLPA indicators, are noted below. Performance targets are subject to change pending negotiations with the Ministry of Health and Long-Term Care. Values indicated below are reflective of fiscal year 2011/12.

Achieve Performance Targets for:	**MLPA Target for 2011/12**
1. Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions [MLPA]	14.7%
2. Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions [MLPA]	18.5%

a. Meet the performance targets set for the funding of telemedicine.
b. Meet the performance targets set for the funding of EPI Nurses.
c. Meet the performance targets set for the funding of Paediatric Nurse Practitioners for Eating Disorders.

These are 2011/12 targets. 2012/13 targets to be negotiated.

What are the risks / barriers to successful implementation and mitigating strategies?

- The readiness of the service providers and their Boards to consider the benefits to the clients and their organizations by moving forward on integration opportunities.
- One-time funding for some of the integration initiative expenses may be required.
- Organization-centric thinking that limits system based improvements.
- Mitigating Strategies: MH LHIN will continue to provide leadership and work closely with local health service providers and community partners to promote culture change and transformational system thinking. Opportunities to address gaps and identified barriers will be sought, examined and implemented as

appropriate.

What are some of the key enablers that would allow us to achieve our goal?

- Technology solutions such as OCAN, IAR and shared assessments.
- Better data on gaps within the current system and the ability to track clients from community to ED to admissions and back.
- Partnerships for collaboration that focus on finding efficiencies in order to increase service.
- Dedicated one-time human resources to lead the integration projects.
- Capacity increase.

3.5 ENHANCING SENIORS' HEALTH, WELLNESS & QUALITY OF LIFE

Description

Over the next 25 years, the fastest growing age cohort in the MH LHIN is those over the age of 75. By 2036, the 65+ age group will comprise 20% of the population, up from 11% today. The MH LHIN has invested considerably in expanding home and community support services for seniors through the Aging at Home Initiatives. This enables a wide range of services to be provided to seniors who wish to continue to lead independent lives in their homes. Over the course of the next year, the MH LHIN will endeavour to focus attention on the development of a fully integrated seniors' strategy that will include initiatives undertaken throughout the last four years as well as focus/re-focus resources on new programs that meet LHIN priorities.

Current Status

1. Specialized Geriatric Services Framework: Programs have been developed to support the needs of the frail older adult and care providers within their own home through a specialized inter-professional team. The implementation of the current programs: falls prevention, urgent geriatric assessment clinics, continence program, geriatric and geriatric mental health outreach services is being led by Trillium Health Centre across the three hospitals in the MH LHIN. The programs aim at decreasing reliance on emergency services and increasing functional and psychosocial health.
2. The Senior Friendly Hospital Strategy: Identified as a cross-LHIN priority for province-wide implementation. Seniors are three times more likely to be hospitalized than younger people and receive care in nearly every area of the hospital. In the MH LHIN, this strategy will contribute directly to the shared health system priorities of reducing emergency department wait times, alternate level of care (ALC) and achieving excellent care for all. It is a significant quality improvement strategy, currently being implemented by the hospitals in the MH LHIN to deliver on Ontario's *Excellent Care for All Act's* mandate to improve the quality and value of the patient experience.
3. CCAC Enhanced Home Care Program: The Enhanced Home Care Program is considered by the MH LHIN to be a "cornerstone" program of the Home First Concept. This program consists of three key services: Wait at Home – Enhanced, Wait at Home-LTC, and Stay at Home. Each of these programs has specific criteria for intake of clients, length of time on the service and amount and volume of services to be delivered. The MH LHIN has set specific yearly targets with the CCAC for the number of clients on service and has continued to monitor monthly costing for the services along with frequency of assessment, length of stay and demand for services. Further funding of this initiative has occurred once evidence of need had been determined. Return on investment for the services has been completed and shows a positive impact – this information will be contained in the Impact Analysis Report due in 2012 (see below) as well as the program evaluation (see 3.1 Evaluation of Programs) due in 2012.
4. Aging at Home Impact Analysis: The analysis is being undertaken by the MH LHIN in 2012 as a further adjunct to individual program evaluation (see 3.1 Evaluation of Programs) funded under the Aging at Home strategy. For the impact analysis, a decision-making framework for the LHIN was identified. This framework is comprised of two elements – decision criteria and decision processes. The decision criteria element highlights four criteria domains consisting of: Strategic Fit, Population Health, System Values and System Performance. It is against these four criteria domains that the Impact Analysis Report will assess the impact of the MH LHIN's Aging at Home initiatives. Specifically the Impact Analysis Report will highlight the key elements, questions and data points under each of the criteria domains to validate whether the programs initiated under Aging at Home funding impacted the MH LHIN's strategic priorities and/or whether areas for improvement/further evaluation are recommended.

5. Seniors' Strategy: In 2012 the MH LHIN will undertake the development of an integrated Seniors' Strategy that will blend the initiatives developed over the last four years as part of the Aging at Home strategy and funding as well as undertake a community engagement process with community providers, hospitals, LTC, clients and their families. This engagement's purpose is to identify gaps and challenges in service provision/needs in order to inform future LHIN program design and subsequent investments/re-allocations. From the information gained, it is the MH LHIN's intent to facilitate further strategies to avoid hospitalization of seniors and to validate as part of the strategy if seniors are those identified as "high-end/heavy users."

Goals

- Achieve the best combination of home and community services for "at risk" seniors to reduce institutionalization.
- Improve access to and coordination of services for seniors.
- Support seniors in managing their own health, wellness and quality of life.
- Provide information in order to inform and validate program design and funding for seniors' initiatives.

Consistency with Government Priorities

Aligns with the province's priorities to reduce ED wait times and ALC days, specifically through the Aging at Home Strategy.

Action Plans	2012/13		2013/14		2014/15	
	Status	%	Status	%	Status	%
1. Implement components of the Specialized Geriatrics Services Strategy	In progress	50%	Complete	50%		
2. Seniors Friendly Hospital: Strategy Implementation	In progress	25%	Complete	25%		
3. CCAC Enhanced Home Care Program	Complete	100%				
4. Aging at Home Impact Analysis	Complete	100%				
5. Develop and Implement a Seniors' Strategy to align with the Ministry's Action Plan for Seniors	In progress	50%	Complete	50%		

How will we measure success?

1. Provincially led initiatives will identify outcome measures (Seniors Friendly Hospital) over the course of the year that will be utilized to measure success.

2. Targets for CCAC services are identified yearly with the CCAC. Quarterly monitoring and monthly financial monitoring have occurred for the last 2 years. Return on investment analysis has been completed for the services to the end of Q3 2011/12 and will be completed to the end of fiscal 2011/12 as part of an Impact Analysis Report for "Aging at Home" and the undertaking of the evaluation of these services in 2012.

What are the risks / barriers to successful implementation and mitigating strategies?

- Community and hospital readiness to achieve transformational culture shift for a senior friendly environment that is more tolerant of individual client choice or risk.
- Costs for the Enhanced Home Care program exceed targeted funding.
- Length of Stay on programs exceeds thresholds as a result of lack of LTC beds for those in the Wait at Home-LTC service and/or inadequate CCAC assessment of clients on services.
- Information achieved through community engagement does not inform adequately to strategically articulate investment/re-allocation of funding.
- Mitigating Strategies: MH LHIN will continue to work closely with local health service providers and partners, primary care and community members to promote culture change and system thinking. Evaluation of current practices and return on investment for implemented projects will be reviewed and guide future planning.

What are some of the key enablers that would allow us to achieve our goal?

- Transportation services to support access to medical appointments and services.
- Capacity increase in community agencies to support people with increased care needs.
- Appropriate program design.
- Accurate investment/re-allocation that addresses strategies to avoid hospitalization.
- Utilization of eHealth tools (e.g. RAI assessments, IAR, Shared Assessment) in order to inform, facilitate and reduce duplication of effort and contribute to better coordination of services for clients.
- Engaged public about their personal health.
- Partnerships for collaboration.
- Change management and leadership – active participation by the LHIN to effect change and balance perspectives.

3.6 STRENGTHENING PRIMARY CARE

Description

Primary care is often the first point of contact a person has with the health system – the point where people receive care for most of their everyday health needs. It is typically provided by family physicians and is key to maintaining and improving our health, and to the quality and sustainability of our local health care system. One of the government's top priorities is to reduce wait times (particularly in emergency departments) and to provide quality family health care for all Ontarians. It is important that residents of the MH LHIN have equitable access to primary health care around the clock which should help to relieve reliance on hospital emergency departments for non-emergent care. The MH LHIN will work with our primary health care providers, including family physicians, nurses, dieticians, mental health professionals, pharmacists, therapists, among others to address our priority of transforming and integrating programs and services to improve overall performance in the local health care system.

Current Status

1. MH LHIN Primary Health Care Steering Committee: comprised of primary health care providers from a variety of settings, this group provides advice to the LHIN on Primary Health Care related to the LHIN's strategic priorities.
2. Primary Care LHIN-Lead Pilot Program: In the Fall of 2011, the Ministry of Health and Long-Term Care announced funding to support a Primary Care Lead in each LHIN to advance health system integration and quality improvement locally.
3. Health Care Connect: In MH LHIN, the areas in Mississauga have the highest number of patients who are unattached and therefore a low Family Physician ratio to the population, due to its rapid residential growth. There are a number of high needs patients as well in the area of South Etobicoke. In keeping with our goal to address health equity, the MH LHIN has been working with Health Care Connect to reduce the number of unattached patients in the LHIN.
4. Health Force Ontario: The LHIN is working closely with the Health Force Ontario Partnership Coordinator to support the recruitment of physicians and other health professionals in the area.

Goals

- Improve access to family health care.
- Increase awareness of primary care physicians of health system partners and available resources.
- Reduction in hospital/institutional care that can be provided through primary care or community resources.

Consistency with Government Priorities

Aligns with the government's priorities to reduce ED wait times, improve the population health of people with diabetes and connect more people without a family physician to primary care. Also supports the following government strategies:

- Open Ontario Plan - providing more access to health care services while improving quality and accountability for patients
- Interprofessional Care: A Blueprint for Action in Ontario: Health Force Ontario (July 2007)

Action Plans	2012/13		2013/14		2014/15	
	Status	%	Status	%	Status	%
1. Leverage the Primary Health Care Steering Committee to develop and implement a community engagement plan for primary health care that reflects the priorities of the LHIN and strengthens communication between primary health care providers, CCAC, CSS, LTC and hospitals	In progress	30%	In progress	30%	In progress	30%
2. Support the Primary Care Lead to achieve identified LHIN priorities	In progress	75%	Complete	25%		
3. Reduce the number of unattached patients, particularly in high need areas	In progress	25%	In progress	25%	In progress	25%
4. Work collaboratively with Health Force Ontario to address health resource challenges	In progress	25%	In progress	25%	In progress	25%

How will we measure success?

In conjunction with the Ministry and Primary Care Physician Leads (provincially), performance indicators for the desired goals of the Primary Care Leads are being identified to measure success.

Themes	Short-Term Indicators Will be measured for a specific geographic area/practice group that the PCPLL is focused on	Intermediate-Term Indicators Baseline by LHIN; sub-analysis initially focused on geographic area/practice group PCPLL is focused on
Timely Access to Primary Care	Primary Care providers providing same day/next day appointments PC Providers providing after hours and weekend coverage	• ER Visits for conditions that could be treated in alternative PC Care settings in LHIN • ER Visits for ambulatory care sensitive conditions (ACSC) patients in LHIN • 30 Day Readmission Rates for ACSC patients • Hospitalization rates for ACSC patients • CTAS IV and V ER Visits • Discharged patients seeing their PC provider in LHIN within 7 days of hospital discharge
Avoidable Hospitalization /ER Visits	Discharge protocols implemented	
Primary Care Provider Engagement and Networks	Primary Care provider awareness of the PCPLL in their LHIN	HCC attachment rates for complex and chronic patients

Once established and finalized, baseline measures and targets will be identified.

What are the risks / barriers to successful implementation and mitigating strategies?

- Providers' availability to participate in events.
- Unattached patients willingness to get a family doctor

- Mitigating Strategies: MH LHIN will work closely and in collaboration with the Primary Care Lead to evaluate engagement strategies and other initiatives to build on successful strategies and /or develop new methods (as required) to support broader engagement across the LHIN.

What are some of the key enablers that would allow us to achieve our goal?

- eHealth
- Capacity Increase
- Partnerships for Collaboration

3.7 eHEALTH (Enabler)

Description

Electronic Health (eHealth) is a critical enabler to our strategic priorities. There are opportunities to improve LHIN wide information integration and build capacity within our community. Over the next few years, MH LHIN will build the infrastructure to support information management across the LHIN in collaboration with other LHINs. We will leverage our existing information assets and implement a shared Information Technology / Information System. MH LHIN will continue to align our eHealth initiatives with Ontario's eHealth Strategy. In particular, we will be supporting the implementation of:

eHealth Priorities:

- Web Based EHR Access
- Portal Services Access Layer
- Information for Clients, Providers and Clinicians – Knowledge Resources
- Shared Electronic Health Record Resources – Registries, Domain Repositories, Applications

Important Influencing Factors and Clarification:

- Efforts are underway to deliver a "Cluster Strategy" with oversight of all eHealth initiatives across the Central Ontario LHINs (MH, CW, C, CE, TC and NSM). The strategy is expected to be delivered in Q2 2012/13.
- Some of the projects mentioned in this section are Provincial in nature and applicable across the Central Ontario Cluster. The participation of the MH LHIN within the Central Ontario Cluster, from an Implementation and Adoption perspective, is yet to be defined.
- Benefit realization measurement is not quantifiable in all cases for all eHealth initiatives. Electronic health system business transformation is an enabler to what would / could be a measurable benefit realization. Some of the stated initiatives do not have a set delivery schedule with a measurable benefit realization defined. The revised LHIN eHealth strategy and Cluster Strategy will provide greater clarification. The state of readiness for the individual health service providers (hospitals, CCAC, community or physicians) varies across the MH LHIN which will also influence the implementation timelines.

Current Status

1. Common Hospital Information System (HIS): Our hospitals are looking at implementing a common HIS. Part of this initiative includes: IS/IT Blueprint (HIS Framework), LHIN wide Decision Support, Information Management Strategic Plan, Shared Service Model, and eHealth Oversight / Governance Model.
2. Diabetes Registry: The Diabetes Registry will be an interactive, real-time information system designed to support better management of diabetes patient care according to recommended guidelines. Using existing provincial databases, the Diabetes Registry will support evidence-based decision making by capturing and trending lab results and dates for kidney function (albumin to creatinine ratio), cholesterol (low-density lipoprotein) and blood sugar levels (glycated hemoglobin / HbA1c). It will also capture the date of the last retinal screening and diabetes check-up. The Diabetes Registry is being led by eHealth Ontario. The Mississauga Halton LHIN is not an early adopter LHIN and it is anticipated in late 2012 that there will be clear direction from eHealth Ontario regarding how the LHINs will be engaged in the Diabetes Registry provincial deployment.
3. Medication Management (Drug Information System & ePrescribing): The goal of the Drug Project is to improve the health of Ontarians through optimal medication management. To enable this goal, the

Strategy has committed to purchase and implement a Drug Information System, create a comprehensive medication profile for all Ontarians and provide clinical decision making tools including adverse drug interaction flagging to healthcare providers. This project is currently under review with the Ministry.

4. Connecting GTA: A clinical integration initiative that will provide healthcare providers with a single point of access to patient health information from multiple sources across the continuum of care. Procurement efforts are under way for: back-end solution (clinical data repository and health information access layer) as well as a front-end portal solution. Twelve data contributor HSPs have been selected through an expression of interest process and currently the same process is being used to select a shortlist of organizations that will have view only access. Expansion planning will follow the success of the current activity.
5. Electronic Medical Record Adoption: Ontario MD led initiative which provides funding and professional services to primary care providers as they adopt an Electronic Medical Record solution within their practices. The EMR Adoption Program is intended to increase the number of Ontario physicians who use certified electronic medical records (EMR) applications in their practice. MH LHIN is gaining adoption and will soon be at the provincial level. The MH LHIN has established a CW/MH LHIN Physician eHealth Steering Committee, through the e-Health Office, to address local physician eHealth adoption. Electronic medical record adoption by Family Practice is at 49% (increase of 8% from September 2011) and the adoption rate of Specialists is at 20%. (Ontario MD Inc., December 2011).
6. Community Care Information Management (CCIM) Program: The strategic vision of Community Care Information Management (CCIM) is to provide seamlessly-integrated, community-based client care where all service providers can securely share and access consistent and accurate information electronically. CCIM consists of two streams and a number of projects to support the Community Care sector.
   The Integrated Assessment Record (IAR) project supports the vision of CCIM and allows Health Service Providers (HSPs) to pull a clinical assessment over view and patient history via a simple web based interface. Also included in the CCIM program is the standardization of common assessment tools, OCAN, RAI, and CHA. It is these assessments that are uploaded into the IAR.
   The IAR successfully went live in the GTA Cluster in November 2011. CCIM continues to support Health Service Providers with their Go-live activities. The CCIM program is scheduled for completion of the IAR implementation by March, 2013.
7. Resource Matching & Referral (Business Transformation Initiative): Today's ALC patient referral landscape across Ontario is complex and is characterized by inconsistent processes for referring clients to programs and services. Providers frequently base referrals on existing relationships and incomplete knowledge of available services rather than on the most appropriate care setting. Significant time and resources are spent on the administrative burden of completing and faxing multiple forms.
   The ALC RM&R BTI project will streamline the provincial referral environment. It will deliver concrete benefits to patients, health service providers (HSP) and health system planners through increased collaboration, standardized referral processes, and joint accountabilities, all which will ensure more efficient, equitable and client-centric care.
   Within Cluster 2 (Central, Central East, Central West, Mississauga Halton, North Simcoe Muskoka, and Toronto Central LHINs), the first round of LHIN-level Fuzion sessions occurred in January 2012, and resulted in common standards for each LHIN. The second round of Fuzion sessions occurred in February 2012. Sector representatives from each LHIN participated to integrate and collaboratively design a more efficient future state to be utilized across the LHIN cluster.
   Throughout the month of April 2012, the Provincial Delivery Lead (St. Joseph's Health System – Hamilton) will be integrating the standards that were developed by each of the 3 clusters into provincial standards.
8. Resource Matching & Referral (Common Solution Implementation): The TC LHIN and eHealth Ontario are eager to continue the momentum that the Provincial ALC RM&R BTI project has created. The TC LHIN and

MOHLTC will jointly develop next steps that are aligned with the Phase II Provincial RM&R Planning document. Phase II will include continued planning and implementation of an RM&R common solution.

9. GTA West Diagnostic Imaging Repository: The implementation and deployment of a Shared Diagnostic Imaging Repository (DI-r) Solution, which enables the GTA West Participating Organizations to share and exchange Digital Imaging (DI) results. The GTA (Greater Toronto Area) West DI-r Project will begin integration of its hospitals over the next year. By the end of 2011-12, approximately 90% of all diagnostic reports and images will be available for viewing and sharing within regional repositories.
10. Hospital Report Manager (HRM): The Hospital Report Manager (HRM) product provides secure integration between hospitals' Electronic Patient Records (EPRs) and regional physicians' Electronic Medical Record (EMR) systems. The HRM product facilitates the secure delivery of medical records, diagnostic imaging and cardio respiratory reports. The shift away from regular mail and fax to electronic delivery is more effective and has laid a strong foundation for the use of Electronic Health Records (EHR) in these regions.
    With a shared focus to improve access to information for health care providers, both the ConnectingGTA and Hospital Report Manager initiatives will collect data from hospitals to share with physicians.
    Given similar objectives, the teams recognized the need to align efforts so that investments and efforts could be leveraged where it makes most sense. The teams have been reviewing activities from both a technical and implementation perspective and they are now working to finalize the roles & responsibilities to coordinate deployment activities.
11. Community Services Provider (CSP) Portal: This project is to implement the first release of a scalable and robust community support services (CSS) portal framework that will provide immediate value to the user community. The portal will enable the delivery of community services and provide the framework for continued releases of valuable functionality based on the future strategic needs of the user groups. Rollout of portal access is complete as of Quarter 4, 2011-2012.

Goals

- Provide the infrastructure and enablers required for the achievement of all strategic initiatives.
- Improve information sharing within communities and across the continuum of care.
- Improve the management and prevention of chronic diseases.

Consistency with Government Priorities

eHealth initiatives align with the government priorities set out in Ontario's eHealth Strategy.

Action Plans	2012/13		2013/14		2014/15	
	Status	%	Status	%	Status	%
1. **Common Health Information System (HIS)** Foundational Components (Regional Governance, Project Mgmt, Privacy & Security, Technology, Communications & stakeholder engagement, Adoption & Sustainably & Regional Technology Capacity). [3 – 5 Year Implementation Program pending funding.]	In progress	25%	In progress	25%	In progress	25%

2. **Diabetes Registry** (also "Prevention & Mgmt of Chronic Conditions")	In progress	15%	In progress	25%	In progress	60%
3. **Medication Management** – Drug Information System & ePrescribing					In progress	15%
4. **Connecting GTA** – Provider Portal & Health Information Access Layer (HIAL) [2012/13 – foundation setting with 12 sites, expansion beyond this in years 2013/14]	In progress	25%	In progress	75%		
5. **Ontario MD physician Electronic Medical Record** (EMR) Adoption Program continuation (also "Strengthening Primary Health Care")	In progress	65%	In progress	35%		
6. **Community Care Information Management** (CCIM) Program initiatives (see section 3.1). Remaining HSPs post-2012/13.	In progress	20%				
7. **Resource Matching & Referral** Business Transformation Initiative (BTI)	Complete	50%				
8. **Resource Matching & Referral**: Common Solution Implementation	In progress	15%	In progress	65%	Complete	20%
9. **GTA West Diagnostic Imaging Repository**	Complete	100%				
10. **Hospital Report Manager (HRM)**	Complete	100%				
11. **Community Services Provider Portal**	Complete	50%				

How will we measure success?

1. In the first stream of the Common Hospital Information System (HIS) project, Rapid Electronic Access to Clinical Health (REACH), which has been implemented in all of our hospitals, will be upgraded so all versions are the same – upgrade concludes Quarter 2 (2012/13), this will be extended to integrate with Hamilton Quarter 3 or later. Movement toward less variation and more standardization and integration of HIS regionally will be realized.
2. For the Connecting GTA project, three out of 4 organizations (CVH, THC and MH CCAC) within the MH LHIN will be feeding data into the clinical document repository within the Quarter 4 time frame.
3. Hospital Report Manager (HRM): By the end of 2012/13, approximately 400 physicians will receive hospital reports through their EMRs.

What are the risks / barriers to successful implementation and mitigating strategies?

- Limited capacity in some health service providers to participate fully in eHealth initiatives.
- Ability to effectively engage stakeholders to support implementation and adoption of initiatives.
- Release of funds delays impact procurement and implementation timelines.

- Mitigating Strategies: MH LHIN will continue to provide leadership and work closely with the Ministry of Health and Long-Term Care, e-health Ontario, local health service providers and community partners to promote culture shifts and system thinking.

What are some of the key enablers that would allow us to achieve our goal?

- Partnerships for collaboration
- eHealth

3.8 FRENCH LANGUAGE HEALTH SERVICES

Description

Under the *French Language Services Act*, a person has the right to communicate in French with the government and receive available services in French. Using the Inclusive Definition of Francophones, the Francophone population in the Mississauga Halton LHIN is approximately 35,000. Roughly 70% of the Francophones live in the Mississauga region and the other 30% are dispersed across the geographical areas of the MH LHIN.

Current Status

1. French Language Health Planning Entity #3 : Under the *Local Health Systems Integration Act*, the MH LHIN, in collaboration with Central West and Toronto Central LHINs, entered into an agreement with the French Language Health Planning Entity #3 (FLHPE) in March 2011. The three LHINs have developed a Joint Annual Action Plan with Entity #3 (now called Reflet Salvéo) outlining five main objectives: Shared Community Engagement Plan, Francophone Community experiences and needs assessment, FLS service map, build knowledge and awareness for health service providers and LHINs and FLHPE capacity building.
2. Health Needs for the Francophone Community: The MH LHIN, in collaboration with Central West LHIN and le Centre de services de santé Peel et Halton Inc., had developed and launched a French Language Services Assessment Study and Needs Survey for Francophones in the LHINs' geographical areas early January 2011. The survey focused specifically on the health care usage and needs of Francophones in the two LHINs.
3. Community Engagement: As part of the MH LHIN's community engagement plan, community engagement events have been organized to share and validate the results of the survey.
4. Access to French Services: The MH LHIN has enlarged the membership of its FLS Focus Group to represent the local Francophone community to enhance access of French services in Mississauga Halton. In order to enhance access to French services in MH LHIN, French Language Services has been embedded in the MH LHIN Performance Indicators in the Service Accountability Agreements for HSPs. The five "Identified" HSPs continue to enhance FLS through their HSP FLS Implementation Plans.
5. Provincial Cross- LHIN Collaboration on Francophone Issues: The MH LHIN participates in provincial meetings with all 14 LHIN FLS Coordinators, and has worked in collaboration with the other Coordinators to address Francophone issues that span across the LHINs.

Goals

- Improved access to French Language Health Services (FLHS) for Francophone residents of the MH LHIN.

Consistency with Government Priorities

Aligns with the government's priority to improve access to French Language Health Services (FLHS) for Francophone residents in Ontario.

Action Plans	2012/13		2013/14		2014/15	
	Status	%	Status	%	Status	%
1. Work with Reflet Salvéo through the joint action plan for 2012/13	Complete	100%				
2. Implement next steps of FLS Assessment Study and Needs Survey for	In progress	50%	Complete	50%		

Francophones						
3. Develop and implement the community engagement plan	Complete	100%				
4. Collaborate with the identified HSPs to develop FLS as per their HSP FLS Implementation Plan	Complete	50%				
5. Work in collaboration with the other LHINs at the provincial level to develop common initiatives for FLS	In progress	30%	In progress	30%	Complete	40%

How will we measure success?

In collaboration with Reflet Salvéo, outcome and process indicators need to be identified. Until these indicators are in place, key measures of success will include soft measures of increasing outreach to the Francophone community (through community engagement event participation and evaluation), identifying Francophone providers within organizations, increasing availability of services in French and customer satisfaction.

What are the risks / barriers to successful implementation and mitigating strategies?

- Supply of French language health professionals.
- Mitigating Strategies: MH LHIN will work closely and in collaboration with Reflet Salvéo and local health service providers to develop strategies to further promote French language services and identify (and support) Francophone health professionals (in identified or non-identified health service provider organizations).

What are some of the key enablers that would allow us to achieve our goal?

- Partnership for collaboration.
- Health Human Resources.
- Francophones engaged about their personal health.

3.9 ENGAGEMENT WITH ABORIGINAL PEOPLE

Description

The *Local Health System Integration Act, 2006* requires that each LHIN, "in carrying out community engagement, engage the Aboriginal and First Nations health planning entity for the geographical area of the network." First Nations, Inuit and Métis peoples approach health in a holistic way – spiritually, mentally, physically, emotionally and socially. In the MH LHIN, there are over 8,000 Aboriginal people with First Nations ancestry (85%) and/or Métis (26%) ancestry. Few people in the Aboriginal Resident Survey self-identified as Inuit.

Current Status

1. Community Engagement with First Nation, Aboriginal and Métis: In its commitment to engage Aboriginal people, the MH LHIN, in collaboration with the representatives of the local Aboriginal and Métis representatives, has developed a work plan to implement the next steps of the Health Needs Assessment Report. As part of the LHIN's community engagement plan, the MH LHIN has funded community engagements events in collaboration with the Peel Aboriginal Network.
2. Inventory of Services for Aboriginal Communities: Work has started on an inventory of traditional healers and services in collaboration with the Peel Aboriginal Network.
3. Provincial Cross- LHIN Collaboration on Aboriginal Issues: MH LHIN Staff collaborate and participate at the provincial LHIN Aboriginal Engagement Network, whose mandate is to engage the fourteen LHINs in joint planning and a consistent approach to Aboriginal Community Engagement and Aboriginal health planning. A consistent approach to the implementation of the legislation and regulations related to the Local Aboriginal Health Planning Entities as defined in LHSIA, 2006 is also part of the mandate of this group.

Goals

- Work with the Aboriginal community to better understand and address issues of access to care.

Consistency with Government Priorities

Aligns with the government's priority to work with the Aboriginal community to better understand and address their health needs and issues.

Action Plans	2012/13		2013/14		2014/15	
	Status	%	Status	%	Status	%
1. Develop and implement a community engagement plan to support a collaborative relationship with First Nations, Métis and Inuit communities based on the Health Needs Assessment report	Complete	100%				
2. Update inventory of services available to Aboriginal communities and inventory of traditional healers (in collaboration with Peel Aboriginal Network and Métis Nation of Ontario)	In progress	50%	Complete	50%		

and develop and implement a communication plan to share the updated information						
3. Work with the 14 provincial Aboriginal Leads to develop and implement a work plan for the Aboriginal communities (both urban and rural settings) for cross-LHIN initiatives	Complete	100%				

How will we measure success?

In collaboration with the provincial LHIN Aboriginal Leads as well as local First Nations, Métis and Inuit communities (and established networks), outcome and process indicators need to be identified. Until these indicators are in place, key measures of success will include soft measures of increasing outreach to the First Nations, Métis and Inuit communities (through community engagement event participation and evaluation) and customer satisfaction.

What are the risks / barriers to successful implementation and mitigating strategies?

- Readiness of health service providers to provide culturally responsive services.
- Mitigating Strategy: MH LHIN will work with local First Nations, Métis and Inuit communities (and established networks) to identify cultural competency opportunities that can be shared with health service providers. Provincial Aboriginal LHIN resources will also be accessed to help identify the most suitable strategies to increase cultural competence.

What are some of the key enablers that would allow us to achieve our goal?

- Partnership for collaboration
- Engaged public about their personal health

4.0 LHIN OPERATIONS AND STAFFING

LHIN OPERATIONS SPENDING PLAN				
LHIN Operations Sub-Category ($)	2011/12 Budget	2012/13 Planned Expenses	2013/14 Planned Expenses	2014/15 Planned Expenses
Salaries and Wages	2,563,780	2,571,123	2,571,123	2,571,123
Employee Benefits				
HOOPP	239,897	257,072	257,072	257,072
Other Benefits	311,866	305,077	305,077	305,077
Total Employee Benefits	551,763	562,149	562,149	562,149
Transportation and Communication				
Staff Travel	15,350	20,000	20,000	20,000
Governance Travel	10,000	5,000	5,000	5,000
Communications	40,000	38,000	38,000	38,000
Other Benefits	-			
Total Transportation and Communication	65,350	63,000	63,000	63,000
Services				
Accommodation	138,224	160,523	160,523	160,523
Advertising	15,000	5,000	5,000	5,000
Banking	-			
Community Engagement	-			
Consulting Fees	94,000	66,000	66,000	66,000
Equipment Rentals	30,000	27,089	27,089	27,089
Insurance	18,000	6,000	6,000	6,000
Governance Per Diems	173,105	105,000	105,000	105,000
LSSO Shared Costs	429,930	336,956	336,956	336,956
Other Meeting Expenses	40,000	35,000	35,000	35,000
Other Governance Costs	45,000	35,000	35,000	35,000
Printing & Translation	18,000	15,000	15,000	15,000
Staff Development	25,000	20,000	20,000	20,000
LHINC	50,000	47,500	47,500	47,500
Other Services	18,000	18,000	18,000	18,000
Total Services	1,094,259	877,068	877,068	877,068
Supplies and Equipment				
IT Equipment	6,000	9,353	9,353	9,353
Office Supplies & Purchased Equipment	51,141	33,000	33,000	33,000
Total Supplies and Equipment	57,141	42,353	42,353	42,353
LHIN Operations: Total Planned Expense	4,332,293	4,115,693	4,115,693	4,115,693
Annual Funding Target	4,332,293	-	-	-
Variance	-	4,115,693	4,115,693	4,115,693

LHIN STAFFING PLAN (FULL-TIME EQUIVALENTS)

Position Title	2011/12 Actuals Mar. 31/11 FTEs	2012/13 Forecast FTEs	2013/14 Forecast FTEs	2014/15 Forecast FTEs
CEO	1	1	1	1
COO	1	1	1	1
Director	2	3	2	2
Manager of Corporate Services	1	1	1	1
Executive Lead, Health System Performance	0	1	1	1
Executive Lead, Health System Development	0	1	1	1
Executive Lead, Decision Support & Information	0	1	1	1
Senior Lead	8	5	5	5
FLS	1	0	0	0
Consultant & FLS	0	1	1	1
Executive Assistant	2	2	2	2
Administrative Assistant	3	2	2	2
Receptionist	1	1	1	1
Program Assistant	1	0	0	0
Manager, Governance & Strategic Relations	1	0	0	0
Executive Lead, Governance & Quality Improvement	0	1	1	1
Planning Analyst	1	0	0	0
Manager, Finance and Risk	1	1	1	1
Senior Lead Funding & Allocation	2	2	2	2
Senior Information Lead	1	0	0	0
Project Coordinator & Data Analyst	1	1	1	1
Lead Communications	1	1	1	1
Financial Clerk	1	0	0	0
Planning & Decision Support	0	1	1	1
Corporate Coordinator	0	1	1	1

5.0 COMMUNICATIONS PLAN

Objectives: What is the purpose of the ABP

The ABP is a guiding document that is critical to the work of the Mississauga Halton LHIN.

The IHSP guides the activities and accountabilities of local health service providers as described in the *Local Health System Integration Act, 2006*. Specifically, it provides an overview of the current health care system identifies areas for focused improvement and sets standards for achievement. It is a local road map to better health, better care and better value-for-money for the health care dollar, for the residents and health service providers in the Mississauga Halton LHIN.

The ABP demonstrates progress made toward reaching the IHSP's two strategic goals. It also provides the opportunity to fine tune strategies for the upcoming year. It provides a framework for communicating to stakeholders the impact local decision making has on health care delivery in our communities.

Context: Why do we do an ABP?

Under the *Local Health Systems Integration Act (LHSIA) 2006*, and the Ministry-LHIN Performance Agreement (MLPA), LHINs are required to publish their Annual Business Plan to inform stakeholders about the LHIN's strategies and initiatives for addressing IHSP priorities. The LHIN's ABP communication plan ensures that all stakeholders have full and easy access to our strategic and operational plans.

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

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

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

Target Audience:

Audiences include:

- Ministry of Health and Long-Term Care
- Internal LHIN Stakeholders
  - Board of Directors
  - Staff
- Advisory and Reference Groups
- Internal to the Health Care System
  - Hospitals
  - CCAC
  - Long-term Care Homes
  - Community Health Centres
  - Community Service Agencies
  - Mental Health and Addictions Agencies
- External Stakeholders
  - Government

- General Public
- Media

Strategic Approach: What type of announcement?

Coordinated, same day release of ABP document for all LHINs (date tbd).

Inclusion of ABP Goals and Action Plan in all on-going communication and community engagement activities.

Tactics:

- Strong local Government Relations
- Communicating with Health Human Resources and Front Line Staff
- Maintaining strong Media Relations
- Organizing Knowledge Building/Information Sharing Events
- Maintaining a consistent toolbox of strong communication vehicles
    - *2009-10 Annual Report*
    - *News Releases*
    - *Website*
- Electronic newsletter – as required
- Maintaining and enhancing community engagement

Communication Plan for Specific Initiatives

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