Mississauga Halton **LHIN**

Mississauga Halton
Local Health Integration Network

Annual Business Plan

April 1, 2013 – March 31, 2014

Ontario
Local Health Integration Network

Mississauga Halton **LHIN**
RLISS de Mississauga Halton

June 14, 2013

Ms. Catherine Brown
Assistant Deputy Minister, Health System Accountability & Performance Division
Ministry of Health and Long-Term Care
Hepburn Block, 5th Floor
80 Grosvenor St.
Toronto ON M7A 1R3

Dear Ms. Brown,

On behalf of the Mississauga Halton Local Health Integration Network Board of Directors, it is my pleasure to submit to you our draft Annual Business Plan (ABP) for 2013 – 2014. This plan outlines initiatives planned and underway in the Mississauga Halton LHIN to support achievement of our new Integrated Health Service Plan (IHSP).

The ABP for 2013-2014 reflects the current local reality in our LHIN and takes into consideration results of ongoing community engagement that occurred over the past year with our health service providers and community. It further recognizes and supports the health care priorities articulated by the Minister of Health and Long-Term Care, namely Heathier People, Healthier Communities and a Healthier System for All.

We are confident that this plan positions the Mississauga Halton LHIN towards achieving our vision of a seamless health system for our communities, promoting optimal health and delivering high quality care when and where needed.

Yours truly,

Graeme Goebelle FCPA, FCA
Chair, Mississauga Halton LHIN Board of Directors

c. Board of Directors

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Mississauga Halton
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Annual Business Plan
2013/14

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1.0 CONTEXT

The MH LHIN launched its third Integrated Health Service Plan (IHSP) 2013-2016 in February 2013. This strategic plan, "*Partnering for a Healthier Tomorrow*" outlines the local health system strategic priorities and identifies key goals and strategies to achieve an integrated health system, along with measures of success to monitor and guide achievement of this plan.

The five key priorities identified in the 2013-16 IHSP, with specific goals, are:

- **Accessible and Sustainable Health Care**
  - Improve access to services to improve consumer flow, quality and safety
  - Support consumers, families and health care professionals to navigate the health care system
  - Improve sustainability of the health care system

- **Family Health Care When You Need It**
  - Improve access to family health care
  - Increase linkages between family health care and other health care providers to improve communication, coordination and integration across the continuum of care

- **Enhanced Community Capacity**
  - Enable people to stay in their homes longer
  - Provide integrated services that bring care closer to home

- **Optimal Health - Mental and Physical**
  - Increase healthy habits and prevention of disease
  - Build partnerships for healthy communities

- **High Quality Person-Centered Care**
  - Support and foster a quality culture across the continuum of care
  - Value people's experiences to support system improvement
  - Apply a health equity lens for the delivery of health care services

The Annual Business Plan (ABP) operationalizes the Integrated Health Service Plan (IHSP) by providing annual goals and action plans for each IHSP priority. The 2013/14 ABP represents year one towards achievement of the priorities noted within the three-year IHSP.

1.1.2 Mandate

The Mississauga Halton Local Health Integration Network (MH LHIN) is a crown agency mandated to plan, fund and integrate the local health system as articulated in the Local Health System Integration Act, 2006.

Home to 1,179,800 people in 2010, the MH LHIN is one of the fastest growing and most diverse LHIN areas in the province. Covering approximately 1,059 square kilometers, the MH LHIN encompasses Halton Hills, Milton, Oakville, Mississauga (excluding Malton) and South Etobicoke (part of the City of Toronto).

The MH LHIN's vision of "*a seamless health system for our communities – promoting optimal health and delivering high-quality care when and where needed*" supports the availability of access to collaborative, equitable and enhanced health care services to improve the health of people within Mississauga Halton.

Over the next 12 months, through its Annual Business Plan, the MH LHIN will implement a number of initiatives that are aimed at advancing the five key strategic priorities.

1.1.3 Overview of the MH LHIN's Current and Future Programs and Activities

The LHIN is served by two public hospital corporations (which includes six sites), 28 long-term care homes (with approximately 4,180 long stay beds), 34 community support service agencies, 11 mental health and addiction service providers and one community care access centre (CCAC). The LHIN holds accountability agreements with each of these providers. These agreements describe the range and scope of services provided, LHIN funding resources required to sustain services and expected outcomes.

All LHIN funded health service providers (HSPs) are guided by our three-year IHSP. These HSPs will work with the MH LHIN to improve the quality of health care delivery across the LHIN.

The key areas of activity within the MH LHIN over the past years have been to:

- Improve access, quality and sustainability of the health system with a particular focus on reducing emergency department (ED) treatment time;
- Develop a regionally integrated system of health care particularly for key services, through the creation of LHIN-wide regional programs;
- Focus on the prevention and management chronic conditions with a particular focus on diabetes;
- Integrate mental health and addictions services to improve access and quality of care;
- Enhance seniors health, wellness and quality of life in order to enable them to stay at home as long as possible with the required community supports;
- Strengthen primary health care to ensure all LHIN residents have access to primary health care when needed.

Significant engagement of the local community with a particular lens on the needs of the Francophone and Aboriginal communities was the overriding principle to the design, planning, implementation and evaluation of programs and services over the past few years.

The values of accountability, holistic approach, innovation, integrity, partnership and respect has enabled the MH LHIN to promote strong, positive relationships with all health service providers and non-service providers working in its region. Our Board has devoted and continues to invest considerable time and resources to advance collaborative governance among health service providers' boards, to be involved in the journey of developing an innovative health care system.

As the LHIN continues to strive for a high quality, innovative, person-centred health care system for its residents, continuous improvements through lessons learned and best practices have helped us shape the activities and new programs in our 2013/14 ABP.

Quality and Person-Centred Care

The *Excellent Care for All Act, 2010* emphasizes the delivery of quality, evidence-based services. In 2013-14, the focus is on developing a quality scorecard across the LHIN region. Work continues on the accreditation of health service providers in the Community Support Services and the Mental Health and Addictions Services sectors.

A person-centred health care system looks to its consumers and community to help define a positive and satisfying patient experience and provide feedback and suggestions on how to improve the system. This ABP focuses on the development of a customer satisfaction survey across the MH LHIN.

Integrated Client Care– Palliative Care Spotlight

The Integrated Client Care Project (ICCP) started out as a multi-year initiative to create a more integrated client care model, with the innovative element of payment for specific outcomes.

Clinical best practices, quality improvement initiatives and outcome-based approaches are intended to foster greater accountability, encourage top performance as well as lead to innovation in the delivery of palliative care services. This aims at improving the value of care for both the client and health care system. Six sites were identified across the province and together the MH LHIN and MH CCAC were chosen as a spotlight site for this initiative.

The MH LHIN and MH CCAC, in collaboration with Spectrum Health Care have implemented in the Etobicoke area the innovative quality improvements resulting from the ICCP-Palliative Initiative's working groups through the Plan-Do-Study-Act (PDSA) cycle. The innovative delivery models developed under this project are currently being reviewed and will be implemented by the MH LHIN's Regional Hospice Palliative Care Steering Committee across the other sub-LHIN areas.

Health Equity

Being one the most culturally and linguistically diverse regions in the province of Ontario, the MH LHIN believes in the principle of equity and respects the diversity of individuals and communities that we serve. Over one third of our residents belong to visible minorities and 40 percent of our residents indicate that their mother tongue is a language other than English or French. Mississauga Halton is also home to 35,730 Francophones and

approximately 4,300 people who self-identify themselves as Aboriginal and approximately 10,000 people who report Aboriginal ancestry/origin.

By recognizing the diversity of needs and resources, the MH LHIN's equity-based approach and commitment is to create equal opportunities for good health for all and reduce avoidable and unjust differences in health among Mississauga Halton residents.

The MH LHIN has been using the Health Equity Impact Assessment (HEIA) tools to inform community funding for 2012-13. This has helped the LHIN identify the unintended impacts of new programs and program expansion across the LHIN.

Health System Funding Reform

The Health System Funding Reform (HSFR) represents a significant culture shift in Ontario's health care system. Historically, hospitals and CCACs have received an across-the-board increase each year regardless of patient needs in the communities they serve. Starting April 2012, HSFR introduced the Patient-Based Funding (PBF) strategy, which takes into consideration the needs of residents served by each of the LHIN's hospitals and CCAC, and the surrounding community.

For the MH LHIN, HSFR represents a different and fresh way of looking at funding based on its population's health care needs. PBF takes the form of Health Based Allocation Model (HBAM) and Quality-Based Procedures (QBP) funding. The HBAM model combines hospital utilization characteristics and projections in population growth to present a picture that reflects local health care needs while QBP reserves a portion of funding allocations based on emphasizing best practice for patient groupings based on disease, diagnosis, treatment and acuity. The first set of QBPs, introduced in FY 2012/13, includes Primary Unilateral Hip & Knee Replacements, Cataract Surgeries and Chronic Kidney Diseases (CKD).

Program/Service Integration

Supports for Daily Living (SDL)

This pioneering and award winning initiative is a collaborative effort among eight approved SDL providers to improve supports to seniors by developing alternatives in the community. The SDL program bridges the gap between scheduled home care visits and long-term care and provides high needs seniors with services in their own home through 24/7 access to supports with onsite personal support workers or mobile patrol. The implementation of the

program has led to a savings of over $13 million over the last three years. This program has helped nearly 3000 high needs seniors in their homes and for this reason avoided placement in long-term care facilities.

The Mississauga Halton Local Health Integration Network has also released a new resource for consistent delivery of vital care options along the local health system's continuum of care for high risk seniors with complex needs – **Supports for Daily Living Resource Manual: A New Vision of Assisted Living for Seniors**.

Behavioural Supports Ontario

The overall goal of the Behavioural Supports Ontario (BSO) project is to enhance health care for Ontarians with responsive behaviours associated with complex and challenging mental health, dementia or other neurological conditions wherever they live- at home, in a long-term care home or elsewhere. Central to the success of the project is creating a system that ensures people are treated with dignity and respect in an environment that supports safety for all and is based on high quality and evidence-based care and practices.

The MH LHIN action plan builds upon current system capacity and initiatives. Specific to behavioural supports, the MH LHIN has made strategic investments in this area such as the provision of outreach teams to support individuals living in Long-term care homes and the development of the first Specialized Behavioural Support Unit under the specialized unit provisions of the Long Term Care Homes Act, 2007.

With these services in place, the action plan focuses upon the imbedding of BSO Staff (BSO Personal Support Workers and BSO registered Practical Nurses) into long-term care homes that will support the structures necessary to improve support for people with responsive behaviours and support ongoing education of other staff in the long-term care home to increase the capacity of all staff to effectively manage responsive behaviours.

Within the community, community support workers, BSO counsellors and additional psychogeriatric resource consultants enhance the supports available to assist families and service providers to better understand responsive behaviours, develop care plans for successful behaviour management and support people to remain in the community as long as possible.

Health System Transformation

Consistent with Ontario's Action Plan for Health Care, enhancing community capacity focuses on transformation of programs and services to deliver the right care in a community setting. Since the inception of the Aging at Home (AAH) strategy beginning in 2008, the Mississauga Halton LHIN has focused on initiatives that would see health service providers across Mississauga Halton working together to build an integrated, efficient, effective and sustainable health system. Many of the initiatives have addressed the health, wellness and quality of life needs of seniors. These initiatives have built upon service strengths, addressed service gaps and system integration problems, such as, moving patients out of hospitals and into their homes when they no longer required acute care and bringing in needed services for recuperation at home or to prevent long-term care admissions or hospital emergency visits. Our focus on seniors and our "learnings" as a result of that emphasis has enabled the MH LHIN to make systemic changes that benefit all patient/client population groups.

Mental Health and Addictions

Large investments in Mental Health & Addictions in 2013/14 will see the Opioid initiative get underway as well as various projects that focus on building capacity in mental health care within the community sector. These projects are in addition to the Community Concurrent Disorders Program (CCDP) that was established in earlier years.

Expansion and Innovation in the Community

One of the largest pieces of work to be undertaken this year as part of the MH LHIN community development will be "***Avoidable Hospitalization and Decreasing Long-term Care Demand***". This work will be undertaken in a two pronged approach.

The first approach targeting avoidable hospitalization will focus on building community capacity in four key pillar strategies and embedding the strategy work into all community agencies as part of their everyday practices. These four strategies include: behavioural management, falls prevention, incontinence and medication management.

The second approach targeting decreasing Long Term Care demand is focusing on building a caregiver respite program that is second to none. The program, entitled ***Caregiver Re-Charge***, is foundationally based in the provision of in-home respite service, facility based respite services, and out-of-home based respite services. The program will be built to

enable caregivers, as the central focus and as a partner in care, to utilize their in home hours of service in whatever configuration they require as well as access adult day programs for respite and eventually facility based respite beds – all part of one program.

A centralized intake will allow caregivers and/or community and/or hospital providers to access one number to call for ease of access and assessment. Building the program also entails knowledge and quality improvement acquisition. As such, the MH LHIN has partnered with the University of Waterloo to embed research capacity into the design of the program from the beginning along with having the project led by a Six Sigma certified resource.

Work will also progress to build a regional training resource for both the Caregiver Re-Charge program and the CSS sector as a whole. This training resource will become the Mississauga Halton LHIN's "Centre of Excellence" for inter-RAI CHA, IAR, RAI-MH and RAI-Palliative instruments as well as contribute to testing for the new RAI Client Self-Assessment instrument.

The regional training resource will also serve a dual purpose to enable training for caregivers in the home on such areas as positioning, turning, feeding, changing dressings, etc. in order to enable caregivers to feel supported in their care. We anticipate that the Caregiver Re-Charge Program will be operational in 2013/14 with capacity expansion based on our vision for the program to take place over the next 2 years.

Building this program and the avoidable hospitalization strategies will be a lasting legacy to increase community capacity. Altogether our action plans for the community in 2013/14 will continue to leverage our past successes and move us toward further innovation and focused system improvement.

Maximize use of technology

Funding to enhance community capacity is being targeted for investments in the area of Information Technology upgrades for the CCAC and the CSS and Mental Health & Addictions sectors. These upgrades will allow consolidation and increased sophistication in reporting data as well as infrastructure replacement at a time of greater reporting requirements specific to RAI-CHA, RAI-MH, OCAN and IAR. The use of technology for faster data flow, greater communication and information sharing as well as creating the foundation for ideas and innovation will be a major focus for the community in the next few years.

Knowledge and quality acquisition

Evaluation of programs and services is a necessary requirement along the road to building community capacity and ensuring performance. Those programs falling under the “Home First” philosophy (i.e.: Wait at Home, Wait at Home Enhanced and Stay at Home) are completing their evaluation cycle. The results from the evaluation will form part of the action plans for enhancing community capacity for 2013/14. The evaluation is completed in March 2013 with plans for operationalizing recommendations throughout 2013/14. The evaluation of the Rapid Response Nursing program will also take place in 2013/14 in order to ensure that information and knowledge to effect changes where needed or to broaden understanding are obtained quickly. The collaborative work already achieved in this program has been nominated for an Ontario Association of Community Care Access Centres (OACCAC) award in 2013/14.

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

The health care system is facing serious challenges: to meet the health care needs of the growing population while being affordable and sustainable. The MH LHIN recognizes that the health system needs to be transformed, a task that requires leadership, innovation, flexibility and adaptability from all partners to work through the fiscal constraints facing the province coupled with limited health human resources and an aging, growing, diverse population in the MH LHIN.

Population Growth in the MH LHIN

The population of Mississauga Halton has grown by 12 percent during the period of 2006-2011. This is the highest population growth rate across the province. The greatest percentage of total population growth occurred in the Town of Milton, which is recognized as the fastest growing community in Canada.

A key consideration for health system planning based on patients’ needs is that the number of people aged 75 years and older will increase 143.4% in the MH LHIN from 2013 to 2030. This increase must be considered in planning and program development in terms of promotion and prevention, as well as health care usage for this population age-group.

Health Human Resources

One of the enablers in the transformation of the health care system is the availability of adequate and skilled health human resources in the Mississauga Halton region. The LHIN will need to ensure that its people have access to the right number and mix of qualified health care providers, now and in the future to maintain and sustain high quality person-centred services.

Health Links

Health Links aims at improving the coordination of care for high needs patients such as seniors and those with complex medical needs. In the MH LHIN, this will be achieved through the development of geographically based health links to encourage greater collaboration and co-ordination between all of a patient's care providers from community to primary care to hospitals. Through this initiative, the Mississauga Halton LHIN is looking at enhancing collaboration among the providers throughout the continuum of care and improving patient transitions within the system.

Focus on High Users

The work undertaken on High Users in the MH LHIN has allowed us to characterize the high users, those patients who use the health care system frequently, both in terms of acute bed utilization and emergency rooms visits. The LHIN has also examined the analysis of high users across its sub-LHIN areas and has cross-analyzed the usage patterns of these patients. With the current fiscal realities, it is imperative that the LHIN analyze ways to reduce acute and ED visits, and promote care in the community setting. The High Users analysis will also play an important role in the development of Health Links to improve transitions across the MH LHIN.

2.0 INTEGRATED HEALTH SERVICE PLAN 2013-2016 PRIORITIES

2.1 Accessible and Sustainable Health Care

2.2 Family Health Care When You Need It

2.3 Enhanced Community Capacity

2.4 Optimal Health – Mental and Physical

2.5 High Quality Person-Centred Care

2.1 Accessible and Sustainable Health Care

IHSP Priority Description

This priority centres on delivering the right care, at the right time, in the right place, for the right cost. The health care system has and will continue to focus on wait times to foster improved access to a variety of services.

To increase access, providers across the continuum of care must link together as an integrated system. This includes the development of regional programs which promote integration of services across the region along with consistent high quality care, increased equity and accessibility.

Ease of navigation within the health care system for both patients and providers throughout the patient's care pathway will also improve access. This is particularly critical during periods of transition where patients need to flow seamlessly through the continuum of care. Without smooth navigation, patients may not receive the care they require in a timely fashion.

Ensuring the health care system is sustainable puts the focus on value for money. It is imperative to provide both good value economically, but also in terms of the quality of care received. Funding should centre on the needs of the patient and be targeted to the provision of evidence-based, safe and effective high quality care. Health System Funding Reform (HSFR) will support the duality of the value proposition emphasizing not only fiscal imperatives, but also patient outcomes.

Current Status

Over the last year, the MH LHIN has concentrated on a number of key innovative projects focused on improving access, which included:

- Implementation of the Behavioural Support Ontario (BSO) project, which enhances the quality and access to health care for MH LHIN residents with behaviours associated with complex and challenging mental health, dementia or other neurological conditions whether they live at home, in a long-term care home or elsewhere;
- Analysis of High Users within the MH LHIN illustrating the profile of the 5% highest users of inpatient acute care and the emergency department (ED). Through the characterization of these patients, the LHIN has begun to target innovative programming to improve quality of care and reduce hospitalizations and ED use for this population;
- Development of the Integrated Orthopaedic Capacity Plan (IOCP) as part of the Quality Based Procedures under the HSFR;
- Implementation of the Rapid Response Nurse role to improve transitional care from the hospital to the community for those with complex needs (high users);
- Enhanced awareness of the needs of Francophone and Aboriginal communities across the LHIN.

The MH LHIN Mental Health and Addictions Integration Advisory Committee have been engaging various stakeholders to develop its vision for a model of care which will result in enhanced access to care. Recommended tactics include:

- Enhancing service coordination and continuity of care through a centralized intake system that will support navigation and transition of patient through the Mental Health and Addictions treatment system;
- Strengthening system links between primary, secondary, tertiary, health, social and behavioural and physical care;
- Improvements in service quality, personal health status, efficiency and cost effectiveness.

PART 2: GOALS AND ACTION PLANS

Goals

- **Improve access to services to improve consumer flow, quality and safety**
    - Establish new ways of working in and with Emergency Departments to reduce wait times
    - Develop innovative and collaborative approaches to reduce unnecessary hospital stays and avoidable hospital admissions and readmissions
    - Leverage evidence-based practices to reduce wait times for priority surgical services (i.e. hips, knees, cataracts, cancer, cardiac bypass)
    - Integrate services to support regional programs and system effectiveness
- **Support consumers, families and health care professionals to navigate the health care system**
    - Begin planning for transitions early and include all care providers, including informal caregivers and family health care
    - Enhance provider awareness and knowledge of the health care system and available resources
    - Provide service navigation to consumers and their caregivers during transitions within the health care system
- **Improve sustainability of the health care system**
    - Develop regional, integrated capacity plans to support health system funding reform (e.g. integrated orthopaedic capacity plan) and implement funding for selected health programs (quality based procedures)
    - Focus on seniors and those individuals who utilize a significant proportion of our health care resources and how to meet their needs with greater efficiency
    - Work in partnership with health care providers and partners to explore maximizing scope of practice, utilizing services in different ways to improve access

Consistency with Government Priorities						
Alignment with Ontario's Action Plan for Health Care, ED/ALC Strategy, Seniors Strategy for Ontario- *Living Longer, Living Well*, Seniors' Friendly Hospital Strategy, Health Links, Community Care Information Management (CCIM), Mental Health & Addictions 10 year Strategic Plan, High Users, the *Excellent Care for All Act,* Advancing High Quality, High Value Hospice Palliative Care Recommendations and Health System Funding Reform (HSFR).						
Action Plans	**2013/14**		**2014/15**		**2015/16**	
	Status	%	Status	%	Status	%
1. Review and evaluation of recommendations of 2012 MH LHIN ED Surge Strategy	Complete	100				
2. Plan and implement Quality Based Procedures as part of Health System Funding Reform	In progress	30	In progress	30	Completed	40
3. Plan and implement the Integrated Hospital Transition Management Project	In progress	30	In progress	30	Completed	40
4. Develop Master Program Plan for capital requirements	In progress	75	Completed	25		
5. Implement regional plan for Hospice Palliative Care in MH LHIN	In progress	30	In progress	30	Completed	40
6. Enhance access to Mental Health and Addictions services	In progress	30	In progress	30	Completed	40
7. Develop and implement a MH LHIN Telemedicine Strategy	In progress	50	In progress	25	Completed	25
8. Leverage the work of the Aging at Home Strategy and transition to a Seniors' Strategy	In progress	30	In progress	30	Completed	40

9. Implementation of No Wrong Door Policy - Toward an "Every Door is the Right Door" Service System	In Progress	80	In Progress	20		

How will we measure success?

Developmental/Monitoring indicators noted below are under development for the 2013-14 fiscal year, with the exception of Hospice Palliative Care.

1. Reduction in the number and rate of ED visits; decrease gridlock in ED over holiday periods
2. Development of standardized care pathways; reducing practice variation among providers; improvement in quality and patient safety indicators
3. Development of new pathways to enhance transitions from hospitals to the community; increased client satisfaction; seamless communication among providers; increased caregiver supports
4. Increase in the number of new services accessible across the region to the growing population
5. Reduction in the number of hospital days attributed for palliative clients
6. Development of access pathways to services; Increase in the number of mental health and addictions clients accessing the services
7. Increase in the number of health service providers and clients using Telemedicine technologies to provide and access care
8. Development of a Seniors' Strategy in MH LHIN that is aligned with recommendations from the Seniors Strategy for Ontario- *Living Longer, Living Well*
9. Improved access to mental health and addiction services in MH LHIN through the No Wrong Door Policy

<u>Hospice Palliative Care</u>:

- Reduction in the total number of hospital days that are attributed to palliative care by 10%
- Increase in the number of patients discharged home with support
- Decrease in average total LOS
- Decrease in number of patients who died in hospital.

Performance Indicators	MLPA Target for 2013/14
Alternate Level of Care (ALC) and Emergency Room (ER):	
1. Percentage of ALC Days [MLPA]	10.5%
2. 90th Percentile ER Length of Stay for Admitted Patients [MLPA]	28.0 hrs
3. 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients [MLPA]	7.0 hrs
4. 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients [MLPA]	4.0 hrs
Surgical and Diagnostic Wait Times:	
5. Percent of Priority IV Cases Completed Within Access Target for Cancer Surgery [MLPA]	90%
6. Percent of Priority IV Cases Completed Within Access Target for Cardiac By-Pass Procedures [MLPA]	90%
7. Percent of Priority IV Cases Completed Within Access Target for Diagnostic MRI Scan [MLPA]	45%
8. Percent of Priority IV Cases Completed Within Access Target for Diagnostic CT Scan [MLPA]	80%
9. Percent of Priority IV Cases Completed Within Access Target for Cataract Surgery [MLPA]	90%
10. Percent of Priority IV Cases Completed Within Access Target for Hip Replacement Surgery [MLPA]	90%
11. Percent of Priority IV Cases Completed Within Access Target for Knee Replacement Surgery [MLPA]	90%
12. Proportion of primary unilateral Hip or Knee Joint Replacement patients discharged home [Stocktake]	90% +/- 9%
13. Average Length of Stay of primary unilateral Hip or Knee Joint Replacement patients discharged home [Stocktake]	4.4 days
14. [***Repeat***] Unscheduled Emergency Visits within 30 Days for Mental Health	16%

Conditions [MLPA]	
15. [***Repeat***] Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions [MLPA]	21%

What are the risks / barriers to successful implementation?

- Stakeholders resistance to change: lack of input and stakeholder commitment/confidence
- Change to scope of capital planning for LHIN
- Client perception of need, i.e. perception that only the hospitals are able to meet their needs
- Multi-stakeholder projects take time to build and foster relationships and projects have to be postponed
- Limited resources available

Mitigation Strategies

- Communicating and identifying the benefits of change in the system to the stakeholders
- Updating scope in project charter and reviewing activities and timelines as necessary
- Educating clients on services available in the community
- Creating principles to foster relationships for working groups/steering committees
- Reviewing resources available in the community

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

- Developing a clear project management charter for each action goal will allow a clear understanding of each goal
- Realigning initiatives which do not meet their intended targets
- Assessing any significant or unexpected event which puts strain on the health care system and determining the appropriate response
- Developing and implementing contingency plans in order to minimize impact
- Research and innovation
- Evidence-based practice
- Quality improvement
- Financial imperatives and workforce
- Community engagement
- Building awareness
- Health system funding reform
- Information management and technological advances

- Collaborative governance
- Communication
- Accountability management
- Partnerships

2.2 Family Health Care When You Need It

IHSP Priority Description

The MH LHIN has identified the need to collaborate with family health care providers to strengthen and improve access to family health care and promote better coordinated health care for people through improved communication among providers.

Through a robust engagement process, the MH LHIN intends to work with family health care providers to identify challenges and opportunities to enhance person-centred, integrated and holistic care to individuals within our LHIN.

Through the development of Health Links, the LHIN will work with health care providers to improve the coordination of care for high needs patients, in particular seniors with complex medical needs. A key focus will be on improving access to timely family health care and building stronger partnerships across the continuum of care.

Current Status

In 2011, there were approximately 900 family physicians in the MH LHIN, practicing in a variety of practice models. Approximately 600 family physicians practice in a patient enrollment model, including 7 family health teams, 24 family health groups and 14 family health organizations. Approximately 860,000 patients (78%) in the MH LHIN belong to a patient enrollment model.

The Electronic Medical Record implementation rate by Family Practices within the MH LHIN (as of March 2013) is 66%. The MH LHIN continues to work with our Physician, Primary Care Lead to identify ways to improve adoption levels.

In 2012, the LHIN appointed a Primary Care Lead to focus on three key areas relating to strengthening primary care:

1. Avoidable hospitalizations/ED visits
2. Timely access to primary care
3. Primary care provider engagement and networks

The Primary Care Lead held four engagement sessions with the primary care providers and to seek their input on strategies and initiatives early on in their development.

A *Primary Care Connections* newsletter has been developed and is designed to inform and engage primary care physicians on the health care initiatives in the MH LHIN region.

On December 6th, the MOHLTC announced the creation of Health Links across the province to improve coordination of care for high needs patients, in particular seniors with complex medical needs. The MH LHIN is in the process of engaging with key stakeholders to create and implementation plan for the establishment of health links across the LHIN, beginning with one early adopter site, South East Mississauga Health Link.

PART 2: GOALS AND ACTION PLANS

Goals

- **Improve access to family health care**
  - Leverage Health Care Connect to support consumers who want or need a family health care provider to get one, particularly for those people who are admitted to hospital or frequently visit the Emergency Department
  - Improve access to same-day or next-day appointments and after-hours care including home visits and mobile clinics
  - Increase access to multi-disciplinary health care teams

- **Increase linkages between family health care and other health care providers to improve communication, coordination and integration across the continuum of care**
  - Improve coordination of care between providers (particularly for complex consumers who are at high risk for readmission or high users of the system) through the development of Health Links
  - Increase capacity of family health care providers to manage an increased complexity of consumer care through the provision of consultations with specialists
  - Improve communication with family health care providers through consistent and timely sharing of consumer information
  - Leverage technology (i.e. electronic medical records, portals, Ontario Telemedicine Network) to promote sharing of information between providers.

Consistency with Government Priorities

Aligns with Ontario's Action Plan for Health Care, ED/ALC Strategy and Wait Times, Health Links, Health Care Connect, Ontario Telemedicine Network, High Users and the *Excellent Care for All Act*.

Action Plans	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
1. Improve transitions by leveraging the development of electronic hospital and emergency discharge	In progress	50	Complete	50		
2. Develop and implement a plan for the establishment of Health Links across the MH LHIN	In progress	50	Complete	50		
3. Implement and Evaluate Rapid Response Nurses (RRN) initiative in MH LHIN	Complete	100				
4. Implement a BSO care pathway for use by primary care to support individuals with responsive behaviours	In progress	75	Complete	25		
5. Implement pre-printed order sets (PPOS) within LTCHs	In progress	50	Complete	50		
6. Develop continuing education models to address diabetes education for pharmacists, primary care and other health care professionals	In progress	33	In progress	33	Complete	34
7. Implement an Endocrinologist Primary Care Consultation program for diabetes care	In progress	50	Complete	50		
8. Implement a 60 second foot screen process for assessment and interventions to support primary care	In progress	50	Complete	50		
9. Operationalize process for measurement of Primary Care Physician LHIN Lead (PCPLL) Program Indicators	Complete	100				

How will we measure success?

Developmental/Monitoring measurements - These indicators are under-development for the 2013-14 fiscal year, except for Behavioural Supports Ontario (BSO), Health Links and Primary Care Physician LHIN Lead Program Indicators (PCPLL). (See below)

1. Increase in the rate of discharged patients with completed transfer record, number of family physicians receiving hospital/ED discharge summary reports
2. Number of Health Links established; % of LHIN's population covered by a Health Link
3. Decreased readmission rate for population served by RRN; % population served seen by primary care within seven days of discharge; % population served received home visit within 48 hours of discharge of hospital
4. Increase in the number of MDs using BSO pathways.
5. Increase in the number of LTCHs using pre-printed order sets (PPOS), increased number of PPOS developed and implemented
6. Increase in education models that address diabetes designed for pharmacists, primary care and other health care professionals
7. Increased access to Endocrinologist Primary Care Consultation program for diabetes care
8. Increase in the number of clients screened and assessed at the primary care level using 60 second foot screen for diabetes
9. See below in Primary Care Physician LHIN Lead (PCPLL) Program Indicators

Behavioural Supports Ontario (BSO):

- % increase in number of physicians trained in BSO approaches
- % increase in number of physicians applying BSO approaches to care
- % increase in number of patients having access to BSO services via their physician.

Health Links:

Category	Health Links Indicators
Operational Metrics	Ensure the development of coordinated care plans for all complex patients
Results-based Metrics	Reduce the time primary care referral to specialist
	Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere
	Ensure primary care follow-up within 7 days of discharge from an acute setting

Primary Care Physician LHIN Lead Program Indicators (PCPLL)

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 Primary 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 • Non-Admitted Minor Uncomplicated 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	Health Care Connect (HCC) attachment rates for complex and chronic patients

What are the risks / barriers to successful implementation?
• Lack of stakeholder buy in • Lack of referrals or use of system (MDs, LTCHs, LTCH physicians) • Differing organizational culture that impact implementation of action plans • Change in funding structures for project implementation (Health Links)
Mitigation Strategies
• Using a phased approach for implementation and targeting key groups, such as seniors with complex needs • Engaging providers at an early stage to collaborate on the action plan • Creating principles to foster relationships for working groups/steering committees • Developing project charters and reviewing activities and timelines as necessary • Reviewing scope of action plans and resources available
What are some of the key enablers that would allow us to achieve our goal?
• Good role models among health service providers to influence adoption of good practice • Education and training can help challenge personal assumptions, beliefs and values, and encourage reflective practice and team working • Organizational incentives that focus more on patient experience and patient outcomes as opposed to financial issues and throughput • Use current networks to build on past relationships • Identify dedicated resources in planning phases • Community engagement • Building awareness • Health system funding reform • Information management and technological advances • Collaborative governance • Communication • Accountability management • Partnerships

2.3 Enhanced Community Capacity

IHSP Priority Description

Funding decisions over the years have focused on investments that impacted our strategic priorities and built community capacity specific to sustaining and/or increasing Community Support Services, enhancing Assisted Living/Supportive Housing, implementing a LHIN-wide Falls Prevention Strategy and Home Support Exercise Program, Capacity Building in Chronic Disease Self-Management, expansion of Geriatric Mental Health Outreach, the LTC Nurse Practitioner Model, implementation of Neuro-Behavioural Services, Education and Consultation to LTC homes and implementation of a Short-Stay Restorative Program.

These beginning initiatives to expand community capacity have continued into 2012/13 and have been joined by such programs as increased Adult Day Programs, Regional Transportation for Adult Day Programs and Medical Appointments, Home Maintenance & Repair, Bathing Programs (in-home and Adult Day), in-home Palliative Care Program, "Re-Charge" Respite Program, Concurrent Disorders-Mental Health and Wait at Home & Stay at Home programs. As initiators of the Home First philosophy along with strategic and extensive funding, the groundwork was laid for the community to become a key dynamic player in the healthcare system.

Current Status

Transformation through improvement is a recurrent theme within our region. The MH LHIN's HSPs have worked together to solve issues in: patient flow, discharging to community services from hospital, increasing the level of acuity accepted into specific community programs, internal hospital processes in designating ALC, changing the mindset that LTC placement was the only option for seniors, building partnerships between and amongst community agencies as well as the CCAC and understanding the subset of patients that were hard-to-serve as a result of socio-economic and/or complex medical conditions. This work continues as part of sustainability and has been joined by focusing attention on discharge transformation whether through coordination of care post-discharge (e.g.: Rapid Response Nurses) or through investigation into what would constitute the best transition/discharge model (e.g.: Integrated Transition Planning Group).

Enhancing community capacity over the last 5 years has enabled the delay of LTC admissions. As the LHIN with the lowest number of LTC beds per capita in the province MH LHIN estimates that 1040 LTC beds would need to have been added to our complement to achieve the same results that have been accomplished through investments in programs and services such as our Supports for Daily Living (assisted living/supportive housing), adult day, in-home bathing, Wait at Home/Wait at Home Enhanced/Stay at Home, Restore, etc.

These same programs and services have also contributed to the MH LHIN's ability to maintain one of the lowest ALC rates in the province. These programs and services that contribute to system change will continue to receive additional investments as part of targeted funding to manage ongoing growth in our region.

PART 2: GOALS AND ACTION PLANS

Goals

- **Enable people to stay in their homes longer**
    - Manage the volume of services in the community to reduce wait times and meet demand for vulnerable populations such as seniors, palliative consumers and those with mental health concerns and addictions
    - Provide support for medication management and instrumental activities of daily living such as meals and homemaking to avoid institutionalization
    - Support caregivers by providing adequate training, respite and coordination of service
    - Ensure appropriate staffing through enhanced training to attract skilled staff to serve consumers with complex needs in the community

- **Provide integrated services that bring care closer to home**
    - Create community centres for health where people can access integrated services that address more than one need in a single stop
    - Address transportation challenges or bring programming to convenient locations (home or community based) to meet the needs of specific target groups
    - Maximize use of technology to bring care closer to home

Consistency with Government Priorities

Alignment with Ontario's Action Plan for Health Care, ED/ALC Strategy and Wait Times, Health Links, Seniors' Strategy- *Live Longer, Live Well*, The *Excellent Care for All Act,* Ontario Telemedicine Network and Home Care and Community Services Act.

Action Plans	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
1. Avoidable hospitalizations: Focus on Incontinence, Falls Prevention, Behaviour, Medication Management	In progress	70	Complete	30		
2. Design and Implementation of a Caregiver Re-Charge program to address in-home, out-of-home and facility based respite needs and services	Complete	100				
3. Research initiative in partnership with the University of Waterloo for the Caregiver Re-Charge Program	In progress	80	Complete	20		
4. Increase capacity of LTCHs to provide enhanced nursing support to residents preventing unnecessary transfer to hospital and reduced hospital length of stay (LOS)	In progress	30	In progress	30	In progress	30
5. Implement a standardized diabetes MedsCheck system across the MH LHIN	In progress	50	Complete	50		
6. Implementation of Home First evaluation results for programs that include Wait @ Home, Wait @ Home Enhanced, Stay @ Home	Complete	100				
7. Centre of Excellence and Training Resource for Caregiver Re-Charge and CSS Sector	In progress	70	Complete	30		
8. Utilization of technology enhancements for reporting, tracking and innovation in services	In progress	50	Complete	50		

9. Improve access to high-quality physiotherapy, exercise and falls prevention classes	In progress	75	Complete	25		
10. Implement improved service commitment for complex care clients and consumers requiring nursing services	In progress	75	Complete	25		
11. Conduct a collaborative community capacity planning study	Complete	100				

How will we measure success?

Developmental/Monitoring measurements - The performance indicators noted below are under-development for 2013-14 fiscal year, except for the Caregiver/Recharge Program in collaboration with the Research initiative and the M-SAA and L-SAA Indicators. (See next page)

1. Development of a plan for avoidable hospitalizations; embed plan in all CSS agencies as a target group and ensure that 4 strategies become a day-to-day reality; determine indicators for outcome achievement within working group designated to lead avoidable hospitalization initiative decrease in % ED visits and hospitalizations linked to falls, medication, behaviours and incontinence
2. Increase in number of caregivers receiving services in-home, caregiver satisfaction ranked as high (determine parameters of targeting for goal – 80%, 90%); call center access is one number to call; caregivers are considered to be partners in care; increased coordination and collaboration among respite providers
3. Knowledge acquisition from research; articles/papers produced
4. Number of LTCH staff that receive training, decreased number of LTCH application refusals
5. Number of providers implementing the MedsCheck system
6. Learning from the evaluation of the Home First evaluation results; review of existing programs and development of new processes for the Home First philosophy
7. Centre of Excellence operational and training/education facilitated
8. Technology is embedded in programs development and review
9. Decrease in the number of hospital admissions, ER visits as a result of a fall
10. Increase in the proportion of seniors (65+) in the MH LHIN that participate in a falls

prevention calls

11. Increase in the proportion of seniors (65+) in the MH LHIN that attend a falls exercise class on a regular basis
12. Increase in the number of Falls Exercise or Falls Prevention classes that are available to MH LHIN residents.

Caregiver/Recharge Program:

Category	Caregiver/Recharge Program Indicators
Access and Flow	Total number of referrals by source
Utilization	Admission: Discharge ratio
	Average hours used in Tier 2 category in Caregiver Recharge Program
Impact	Number of ER visits diverted
	% decrease in Caregiver Strain Index (CSI) for caregivers who receive service upon discharge from program

Service Accountability Agreement (M-SAA and L-SAA) :

Category	Indicators
Multi-Service Accountability Agreement (M-SAA)	• Average number of days waited for First Services in CSS sector (by functional centres) • Average number of days waited from Referral /Application to Initial Assessment Complete • Average number of days waited from Initial Assessment Complete to Service Initiation • Client experience
Long Term Care Home Multi-Service Accountability Agreement (L-SAA)	• Long Stay Utilization • Median Wait Time (WT) to placement in LTC home • Compliance Status • Debt service coverage (DSC) ratio for non-municipal homes, organizations

MLPA: Performance Indicators for Enhanced Community Capacity	MLPA Target for 2013/14
Alternate Level of Care (ALC):	
1. Percentage of ALC Days [MLPA]	TBD
Access to Community Care:	
2. 90th Percentile Wait Times for CCAC In-home services-Application from community setting to first CCAC service (excluding case management) [MLPA]	21 days
3. [***Repeat***] Unscheduled Emergency Visits within 30 Days for Mental Health Conditions [MLPA]	16%
4. [***Repeat***] Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions [MLPA]	21%

What are the risks / barriers to successful implementation?
• Aggressive timeline pressure and implementation may compromise the quality of the plan • Availability of quality data for evaluation • Industry may be slow to change/change overload • Lack of uptake and support from LTCH operators and for MedsCheck • Willingness and attitude in being open to new thinking • Pre-conceived ideas that box-in/stereotype patient/client groups (e.g.: seniors are not computer literate) • Inability/unwilling to challenge thinking and “old” ways of doing things
Mitigation Strategies
• Developing a project charter and reviewing activities and timelines as necessary • Identifying data points and reference year for data collection • Engaging providers at an early stage to collaborate on the action plan • Creating principles to foster relationships for working groups/steering committees • Re-direct/re-allocate funding • Create a joint vision for outcome attainment
What are some of the key enablers that would allow us to achieve our goal?
• Use of the model for improvement to build a new program that addresses caregiver needs and provides respite for the caregiver • Engage in Plan-Do-Study-Act (PDSA) cycle for quality improvements • Research • Data • Community engagement • Building awareness • Health system funding reform • Information management and technological advances • Collaborative governance • Communication • Accountability management • Partnerships

2.4 Optimal Health- Mental and Physical

IHSP Priority Description

Achieving optimal health, including both mental and physical health, is a goal that everyone strives towards. In order to achieve optimal health we must focus on activities that support and improve the health status of people living with current chronic diseases as well as promoting healthy lifestyles and preventing the occurrence of chronic diseases in our community.

Chronic diseases such as heart disease, high blood pressure, diabetes and asthma account for 6 of 10 deaths in the Mississauga Halton LHIN. Chronic conditions also represent one quarter of all acute hospital days and the majority of high users of our health care system have one or more chronic condition. At the same time the prevalence of mental health and addiction issues are increasing for both adults and youth within our community.

To achieve optimal health for our community, and build a high quality, sustainable health care system, we must continue to work with our current health service providers to improve delivery of chronic disease services and increase our collaboration with community partners such as Public Health Units, local Recreation Departments and social service organizations to enhance both the promotion of healthy lifestyles and prevention of chronic diseases.

Current Status

On February 1, 2013, the Ministry of Health transferred the responsibilities and functions of the MH Diabetes Regional Coordination Centre (DRCC) to the MH LHIN. To continue to achieve objectives of the Ontario Diabetes Strategy, the MH LHIN is integrating previous DRCC activities and functions into the LHIN structure, as well as specific activities including;

- Funding of centralized intake for regional diabetes services
- Funding of a Diabetes self -management website

In combination with the transfer of DRCC responsibilities, the LHIN has also received responsibility for the funding and accountability of paediatric and hospital based adult diabetes education programs (DEPs).

The MH LHIN has established a Chronic Disease Program Management committee to explore and recommend a model for the integration of chronic disease services including access to services and collaboration between chronic disease specialists and programs.
The LHIN has facilitated the development and implementation of a community based exercise and education program (Breath Better, Live Better) within four locations across the LHIN to improve the quality of life for people diagnosed with COPD.

PART 2: GOALS AND ACTION PLANS

Goals

- **Increase healthy habits and prevention of disease**
  - Leverage existing resources for chronic disease and develop an integrated model and approach to chronic disease prevention and management that supports individuals through their lifespan
  - Partner with Public Health to support approaches to healthy lifestyles and disease prevention
  - Promote healthy workplace policies, leading by example through the work of our health service providers

- **Build partnerships for healthy communities**
  - Develop partnerships across various sectors such as municipalities, public health, education and social services to collaborate on issues relating to or impacting health such as the social determinants of health
  - Leverage the expertise of people with lived experience and expand/develop peer support initiatives and networks

Consistency with Government Priorities

Alignment with Ontario's Action Plan for Health Care, ED/ALC Strategy and Wait Times, Seniors' Strategy- Live Longer, Live Well, the Excellent Care for All Act, Ontario Telemedicine Network, Mental Health and Addictions 10- year strategy and Home Care and Community Services Act.

Action Plans	2013/14		2014/15		2015/16	
	Status	%	Status	%	Status	%
1. Develop and implement a regional Integrated Chronic Disease Prevention and Management Strategy	In progress	50	Complete	50		
2. Design and implement centralized intake for patients with Chronic Diseases	In progress	75	Complete	25		

3. Establish service accountability agreements for Diabetes Education Programs (DEPs) transferred to the LHIN from the MOHLTC	In progress	100				
4. Implement core Diabetes education practices across all MH LHIN Diabetes Education Programs (DEPs): An interface with Central Intake Program	In progress	75	Complete	25		
5. Common referral form: a. Standardize communication between Diabetes services and referral sources b. Review form and update/disseminate across LHIN region	Complete	100				
6. Develop Wait Time evaluation strategy for DEPs in partnership with Stakeholders and the LHIN	Complete	100				
7. Expand partnerships for implementation of new “Breathe Better – Live Better Program “ Community COPD Education programs	In progress	50	Complete	50		
8. Establish external partner linkages to develop promotion and prevention of chronic disease strategies	In progress	50	In progress	25	Complete	25

How will we measure success?

Developmental/Monitoring - The indicators noted below are under-development for 2013-14 fiscal year, except for the Diabetes Program. (See below)

1. Decrease in the number and rate of ED visits and hospitalizations for chronic disease
2. Standardized care pathways for chronic diseases patients; increase in client satisfaction and client outcomes; increased collaboration among providers
3. Signed agreements for all DEPs transferred to the MH LHIN.
4. Decrease in the number of ED visits associated with diabetes mismanagement
5. Standardized communication and processes among Diabetes centres and referral sources
6. Development of Wait Time evaluation strategy
7. Increase in the number of people referred to and receiving service from "Breathe Better – Live Better" program locations
8. Increase the number of residents who receive healthy lifestyle education and chronic disease prevention education.

Diabetes Program Indicators:

- Improved client service model for MH region including establishing performance metrics that appropriately reflect key quality indicators from user perspective and as required to measure performance by the MH LHIN
- Improved understanding of client need and quality of client experience
- Increased engagement of primary care providers who serve at risk residents through referrals to Diabetes Education programs (DEPs) or to services provided by mobile team
- Effectiveness of the Central Intake Program (CIP)

Performance Indicators	MLPA Target for 2013/14
1. Readmission within 30 Days for Selected CMGs [MLPA]	13.5%
a) Readmission within 30 Days for Pneumonia [Stocktake]	9.24%
b) Readmission within 30 Days for Gastrointestinal [Stocktake]	15.65%
c) Readmission within 30 Days for Cardiovascular [Stocktake]	7.56%

d) Readmission within 30 Days for Congestive Heart Failure [Stocktake]	19.20%
e) Readmission within 30 Days for Chronic Obstructive Pulmonary Disease [Stocktake]	18.04%
f) Readmission within 30 Days for Cerebrovascular Accident [Stocktake]	8.74%
g) Readmission within 30 Days for Diabetes [Stocktake]	13.82%
2. ***[Repeat]*** Unscheduled Emergency Visits within 30 Days for Mental Health Conditions [MLPA]	14.1%
3. ***[Repeat]*** Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions [MLPA]	18.2%
Stocktake of Q1 2012/13.	

What are the risks / barriers to successful implementation?

- Lack of consensus and support among key stakeholders
- Shortage of quality data for evaluation

Mitigation Strategies

- Identifying outcomes and getting buy-in from all stakeholders; engaging with existing providers at an early stage to collaborate on the action plan; developing project charter and reviewing activities and timelines as necessary; creating principles to foster relationships for working groups/steering committees
- Identifying data points and reference year for data collection

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

- Leadership among health service providers
- Provider and staff knowledge translation and engagement
- Community engagement
- Building awareness
- Health system funding reform
- Information management and technological advances
- Collaborative governance
- Communication
- Accountability management
- Partnerships

2.5 High Quality, Person-Centred Care

IHSP Priority Description

The health care system is playing a vital role in improving health care services for Ontarians by working toward new standards set out in the *Excellent Care for All Act,* in 2011. Still in its infancy, this act has been the cornerstone in enhancing quality health care services, providing best evidence and standard care to patients, listening to the voices and feedback of patients and focusing on quality of care and the optimal use of resources.

The Mississauga Halton LHIN (MH LHIN) has experienced vast demographic changes over the last few years and is one of the fastest growing and most diverse LHIN areas in the province. New populations have emerged as immigrants disperse across the Mississauga Halton region. Such demographic shifts affect health care in a variety of ways, particularly in the way health care is delivered. With more diverse cultures and languages, health care providers now must tailor the health care they provide to individuals to ensure that care is equitable and person-centred.

The Excellent Care for All Act (ECFAA) defines quality using the nine attributes of a high performing quality health system. The MH LHIN will work to ensure that processes are in place that are measurable and meet the dimensions of a high performing health system. During the time frame covered by this annual business plan, the MH LHIN will focus on three attributes "safe", "accessible" and "effective" ensuring that at all times "person-centred" is top-of-mind. The MH LHIN believes that quality improvement focused on reducing health disparities and promoting health equity is vital to ensuring better health for its residents now and in the future.

Current Status

As part of the ECFAA implemented in the hospitals, the two hospital corporations, Trillium Health Partners and Halton Healthcare Services are required to develop and publicly post a Quality Improvement Plan (QIP) at the beginning of each fiscal year. The QIP is an important tool to both document and review current performance in a variety of areas by outlining the priorities for quality improvement and the strategy for implementation. This plan also focuses the hospitals to continually enhance care for the patients, improve the patient experience and achieve even better clinical outcomes.

At a LHIN level, quality and client experience have been two foci over the last year through the implementation of the Ontario Common Assessment of Needs (OCAN) in mental health and addictions agencies and the Inter-RAI CHA and Screener for community care settings. Accreditation of community providers have been a part of an important quality initiative in MH LHIN. Around one-third of the community health service providers have already been

accredited with completion required for 2013.

The MH LHIN has been working with identified health service providers to develop French Language services offered to its French speaking residents. Over the last year, the MH LHIN has worked closely with the French Language Health Planning Entity (Reflet Salvéo) to build stronger connections in the community and to better understand the needs of the Francophone community. A project on the continuum of French Language Health Services has been undertaken with the Entity to determine the best utilization of resources and guide the planning process for French language services.

The MH LHIN has also been reaching out to Aboriginal stakeholders in its region and has been able to solidify partnerships with the Credit River Métis Council, the Peel Aboriginal Network and Métis Nation of Ontario. These concrete relationships have been established and have opened the way to better understanding the needs of our Aboriginal communities and will help in developing culturally appropriate training for health service providers to meet those needs.

While the MH LHIN will develop focused plans for both the Francophone and the Aboriginal communities, the Health Equity plan will include the broader community to reduce health disparities and promote equity in access of health services. A working group with health service providers, community agencies and partners has been set up to start the conversation on Health Equity. Both Francophone and Aboriginal communities are represented on the Health Equity Think Tank. This working group provides an opportunity to share best practices, identify synergies and develop partnerships to leverage a strategy to address local health inequities and develop a regional strategy on health equity across the MH LHIN.

PART 2: GOALS AND ACTION PLANS

Goals

- **Continue to support and foster a quality culture across the continuum of care**
    - Implement the Excellent Care for All Act at a local level to embed a culture of quality within all LHIN health service providers
    - Develop mechanisms for tracking quality of care, safety and system effectiveness as it pertains to desired outcomes
    - Implement consistent care pathways and standardized care plans (i.e. discharge plans)
    - Use scientific evidence to support effective utilization of health care dollars

- **Value people's experiences to support system improvement**
  - Identify person experience metrics and use to guide service improvement and development
  - Ensure services are flexible to meet consumer and caregiver needs
  - Include people with lived experience as active members of planning and quality improvement teams
  - Develop a LHIN-wide customer service focused approach

- **Apply a health equity lens for the delivery of health care services**
  - Raise awareness and decrease stigma to minimize marginalization
  - Focus on the most vulnerable populations and develop awareness and understanding of health equity issues to support these in need
  - Support the provision of services which are linguistically and culturally competent
  - Work in collaboration with the French Language Service Entity (Reflet Salvéo) and Aboriginal leaders to leverage existing capacities and explore new opportunities to meet the respective needs of the Francophone and Aboriginal communities to meet the respective needs of the Francophone and Aboriginal communities

Consistency with Government Priorities

Alignment with Ontario's Action Plan for Health Care, Health Quality Ontario and The *Excellent Care for All Act.*

Action Plans	**2013/14**		**2014/15**		**2015/16**	
	Status	%	Status	%	Status	%
1. Develop a Board Quality Scorecard for the MH LHIN	Complete	100				
2. Implement consistent indicators for client satisfaction in all sectors	Complete	100				
3. Caregiver Strategy: Research Design for program	Complete	100				
4. Design and Implement the Health Equity plan across the MH LHIN	In progress	40	In progress	30	Complete	30

5. Implement LHIN specific elements of the 2013-14 Joint Annual Action Plan (JAAP) created in collaboration with CW LHIN, TC LHIN and the French Language Health Planning Entity (Reflet Salvéo)	Complete	100				
6. Design and implement MH LHIN Aboriginal Cultural sensitivity plan	In progress	60	Complete	40		
7. Finalize OCAN and Inter-CHA shared assessment with all CSS and MH&A HSPs	In progress	90	Complete	10		
8. Implementation of Health Quality Ontario's (HQO) (Ontario Health Technology Advisory Council) Recommendations	In progress	30	In progress	30	Complete	40

How will we measure success?

Developmental/Monitoring – the indicators noted below are under-development for 2013-14 fiscal year, except for the French Language Services Program and Customer Satisfaction (See below)

1. Development of a MH LHIN Board Quality Scorecard
2. Implementation of consistent client satisfaction indicator in all community HSPs across the MH LHIN
3. Enhanced equitable access to Caregiver program in MH LHIN
4. Increase in awareness of Health Equity in service delivery in the MH LHIN; increased awareness of anti-stigma for specific populations in MH LHIN; number of HSPs implementing the Health Impact Assessment (HEIA) Tool
5. Outreach to the Francophone community (through community engagement event participation and evaluation), identifying Francophone providers within organizations, increasing availability of services in French and client experience and other measures as identified by Reflet Salvéo
6. Number of LHIN and HSP staff receiving Aboriginal cultural sensitivity training

7. Number of CSS and Mental Health and Addictions HSPs using the OCAN and interRAI-CHA shared assessments amongst the like agencies as well as in partnership across sectors including the CCAC
8. Measures as identified by HQO (anticipated in 2013-14)

Service Accountability Agreement (LHIN Specific Performance Obligations) :

Category	Indicators
Customer Satisfaction	• Overall rating of the care received at/through an agency • Recommendation of program to a friend in need of similar help
French Language Services	• Targets and Indicators as per the French Language Services Implementation Plan • Bi-yearly report on French Language Services Implementation Plan

What are the risks / barriers to successful implementation?

- Implementing change management among stakeholders
- Lack of consensus and support among key stakeholders

Mitigation Strategies

- Identifying outcomes and getting buy-in from all stakeholders; engaging with existing providers at an early stage to collaborate on the action plan
- Developing project charter and reviewing activities and timelines as necessary; creating principles to foster relationships for working groups/steering committee

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

- Clinical leadership to drive the development or implementation of the action plans
- Stakeholders engagement for buy-in
- Evidence-Based standards to support the action plans
- Community engagement
- Building awareness
- Health system funding reform
- Information management and technological advances
- Collaborative governance
- Communication
- Accountability management
- Partnerships

3.0 LHIN OPERATIONS AND STAFFING PLANS

LHIN OPERATIONS PLAN

LHIN Operations Sub-Category ($)	2012/13 Budget	2013/14 Planned Expenses	2014/15 Planned Expenses	2015/16 Planned Expenses
Salaries and Wages	2,416,697	3,194,429	3,404,968	3,404,968
Employee Benefits				
HOOPP	280,399	340,497	340,497	340,497
Other Benefits	436,176	379,642	379,642	379,642
Total Employee Benefits	716,575	720,139	720,139	720,139
Transportation and Communication				
Staff Travel	20,000	30,000	27,000	27,000
Governance Travel	5,000	9,000	6,000	6,000
Communications	38,000	33,000	33,000	33,000
Other Benefits				
Total Transportation and Communication	63,000	72,000	66,000	66,000
Services				
Accommodation	160,523	290,577	287,269	287,269
Advertising	5,000	15,000	15,000	15,000
Banking	-	-	-	-
Community Engagement	-	-	-	-
Consulting Fees	66,000	96,430	96,430	96,430
Equipment Rentals	27,089	21,589	26,500	26,500
Insurance	6,000	6,500	6,000	6,000
Governance Per Diems	105,000	90,000	91,800	91,800
LSSO Shared Costs	336,956	347,098	351,667	351,667
Other Meeting Expenses	35,000	29,000	35,000	35,000
Other Governance Costs	35,000	25,000	30,000	30,000
Printing & Translation	15,000	23,000	20,000	20,000
Staff Development	20,000	37,000	38,000	38,000
LHINC	47,500	47,500	47,500	47,500
Other Services	18,000	34,257	20,000	20,000
DRCC INTAKE PROGRAM - Transfer to HHC		300,000	300,000	300,000
ONE-TIME Start-up COST (DRCC)		59,000	-	-
Total Services	877,068	1,421,951	1,424,166	1,424,166
Supplies and Equipment				
IT Equipment	9,353	8,976	9,976	9,976
Office Supplies & Purchased Equipment	33,000	45,825	41,682	41,682
Total Supplies and Equipment	42,353	54,801	51,657	51,657
LHIN Operations: Total Planned Expense	4,115,693	5,463,319	5,351,916	5,351,916
Annual Funding Target	4,115,693	5,463,319	5,351,916	5,351,916
Variance	-	0	-	-

LHIN STAFFING PLAN (FULL-TIME EQUIVALENTS)				
Position Title	**2012/13 Actuals Mar. 31/11 FTEs**	**2013/14 Forecast FTEs**	**2014/15 Forecast FTEs**	**2015/16 Forecast FTEs**
CEO	1	1	1	1
COO	1	1	1	1
Director	3	3	3	3
Manager of Corporate Services	1	1	1	1
Executive Lead, Health System Performance	-	1	1	1
Executive Lead, Health System Development	1	1	1	1
Executive Lead, Decision Support & Information Mgt	1	1	1	1
Senior Consultant	6	9	9	9
Executive Assistant	2	3	3	3
Administrative Assistant	3	3	3	3
Receptionist	1	1	1	1
Program Assistant	-	-	-	-
Manager, Governance & Strategic Relations	-	-	-	-
Executive Lead, Governance & Quality Improvement	1	1	1	1
Planning Decision Support	1			
Manager, Finance and Risk	-	-	-	-
Senior Lead Funding & Allocation	2	2	2	2
Senior Information Lead	-	-	-	-
Project Coordinator & Data Analyst	1			
Decision Support & Information Mgmt Lead		2	2	2
Decision Support & Information Mgmt Analyst	-	1	1	1
Lead Communications	1	1.5	1.5	1.5
FLS Coordinator	1	1	1	1
Financial Clerk	-	1	1	1
	27	34.5		
NOTE: Budget and FTE's reflect Operations and DRCC				
DRCC Breakout is as follows:				
Salary & Benefits	1,138,184			
Operations	150,443			
one Time (2013/13)	59,000			
	1,347,626			

4.0 COMMUNICATION PLAN AND COMMUNITY ENGAGEMENT PLAN

4.1 Communication Plan

Objectives

Business Objective:

In line with our vision, the Mississauga Halton LHIN 2013-14 Annual Business Plan operationalizes the goals contained in the LHIN's 2013-2016 Integrated Health Services Plan: *Partnering for a Healthier Tomorrow*, specifically:

- **Accessible and Sustainable Health Care**
  - Improve access to services to improve consumer flow, quality and safety
  - Support consumers, families and health care professionals to navigate the health care system
  - Improve sustainability of the health care system

- **Family Health Care When You Need It**
  - Improve access to family health care
  - Increase linkages between family health care and other health care providers to improve communication, coordination and integration across the continuum of care

- **Enhanced Community Capacity**
  - Enable people to stay in their homes longer
  - Provide integrated services that bring care closer to home

- **Optimal Health - Mental and Physical**
  - Increase healthy habits and prevention of disease
  - Build partnerships for healthy communities

- **High Quality Person-Centered Care**
  - Support and foster a quality culture across the continuum of care
  - Value people's experiences to support system improvement
  - Apply a health equity lens for the delivery of health care services

Communications Objective:

- Raise awareness of:
    - Mississauga Halton LHIN's role in Ontario's transformation of the health care system by strengthening relationships with local MPPs and community leaders and providing timely concise information
    - the caliber of work and credibility of the LHIN in leading and managing transformation of the health system in Mississauga Halton by increasing media awareness of positive LHIN developments, personalizing our message and communicating with real stories.

- Educate and build awareness among health service providers
    - the shared accountability of the Mississauga Halton LHIN and health service providers in transforming the health system
    - their role to identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services based on funding available

- Guide the communications of the Mississauga Halton LHIN (Board and staff) and health service provider partners involved in initiatives contained in the 2013/14 Annual Business Plan to ensure target audiences are reached and messages are clear.

- Work in partnership with individuals and groups to enhance Mississauga Halton LHIN communication efforts locally to align and share key messages, build stronger trusted relationships.

- Raise awareness among LHIN residents of programs and initiatives that support optimal physical and mental health in the Mississauga Halton region.

Context

- Ontario's Action Plan for Health Care, announced by the Minister in January 2012, which is consistent with the principles of the Excellent Care for All Act (2010), puts LHINs at the centre of health system transformation.

- The MH LHIN has a critical role to play in key provincial initiatives recently introduced such as Health System Funding Reform, Health Links, Seniors Strategy and the expansion of Quality Improvement Plans into the primary and community care sectors.

- The MH LHIN's 2013-16 IHSP and the initiatives laid out in this Annual Business Plan

are strategically aligned with government directions and priorities and recognize the joint accountability of the ministry and LHINs to serve the public interest and effectively oversee the use of public funds.

- The health care system has evolved to the point where LHINs are being recognized as the local system managers who play a central leadership role in driving health system transformation.

Target Audience

Depending on the situation, primary and secondary audiences will include but not be limited to:

- Health Service Providers and Key Stakeholders (LHIN-wide, cross-LHIN and pan-LHIN)
    - MH Health Service Providers – Administrative and Governance
    - Primary Care Providers including physicians
    - Patients, clients, consumers, and residents
    - Professional Associations such as Ontario Hospital Association (OHA), Ontario Medical Association (OMA)

- Government – Administrative Leadership and Elected Officials
    - Municipal
    - Regional
    - Provincial – including MOHLTC stakeholders

- General Public
    - Residents
    - Patients/client
    - Caregivers/family members
    - Community Organizations

- Media

- Ministry of Health and Long-Term Care and other ministries (as appropriate and required
    - LHIN Liaison Branch (LLB)
    - Communications and Information Branch (CIB)
    - Minister's Office (MO)

Strategic Approach

- Provide information on performance and progress– document successes and share it.
- Showcase and communicate to stakeholders including the public, specific examples of program accomplishments and how they benefit our region. These examples will position the LHIN as a valued key player within the transformation of Ontario's health system and as the lead in health system transformation in Mississauga Halton region;
- Develop and leverage opportunities to build our reputation and establish credibility including encouraging third-party experts to express publicly their opinion and comments on Mississauga Halton LHIN program and operational achievements;
- Stakeholders understand the rationale for change, the transformational model and the plans for implementation;
- Leaders are engaged to champion change throughout the region;
- Provide tools that help ambassadors explain the value of the LHIN;
- Align the health service providers to the shared vision, mission, values and common direction of helping Mississauga Halton LHIN residents spend more time in their homes and their communities;
- Mitigate communications risks of negative publicity by proactive planning of risk reduction.

LHIN Key Messages

- Mississauga Halton LHIN is a key partner in transforming the health system to provide quality care that meets the needs of Ontarians today and into the future;
- The Mississauga Halton LHIN brings together health care partners to develop innovative, collaborative solutions leading to more coordinated, value-driven model that promotes wellness and a better patient experience;
- Mississauga Halton LHIN's focus is on meeting the needs of people in the Mississauga Halton region, providing local decision-making and increased accountability to ensure delivery of the right health care at the right time in the right place;
- By talking and listening to local health care providers and community residents, and through careful strategic planning, the Mississauga Halton LHIN identifies and funds local initiatives;
- The Mississauga Halton LHIN is committed to making the experience of care more seamless and easier to navigate.
- Everyone has an important role to play in making healthy change happen, including health-service providers, the LHINs, community leaders and the public.

Tactics

The communication/engagement tactics will flow out of an overarching communications strategy that guides alignment of all audience- and initiative-specific communications plans.

Tactics and tools will differ for each initiative drawing from the following:

- Mississauga Halton LHIN website
- Annual community bulletin
- Video (Mississauga Halton LHIN YouTube Channel)
- News releases/launches/local announcements
- Joint communications with HSPs
- LHINfo Minutes
- Board updates
- Area provider table monthly updates
- Email blasts to stakeholders
- Face-to-face community engagement
- Newsletters
- Surveys
- Presentations
- Advertising
- Public meetings

Evaluation

Success of the communication plan will be measured with the following:

- Participation levels in engagement sessions and LHIN-wide committees
- Key stakeholders are quoted using information from engagement sessions or other communiques.
- The number of newspaper articles mentioning the Mississauga Halton LHIN
- The volume and tone of editorial coverage
- On-line surveys
- Evaluation forms at face-to-face engagement sessions
- By year end, CEO and Board Chair have met with local MPPs and Mayors
- LHIN spokesperson is quoted in key media outlets
- You tube and website traffic
- Interviews with a handful of individuals who represent the base of our audience
- Focus Groups

4.2 Community Engagement Plan

Engagement on LHIN Priorities
The MH LHIN's priorities as defined in the Integrated Health Service Plan (IHSP) 2013-16 are: accessible and sustainable health care, enhanced community capacity, family health care when you need it, optimal health – mental and physical and high quality person centered care. In this Annual Business Plan (ABP), the LHIN aims to focus on the person experience and will target to have consumer and caregiver representation across its various committees. The LHIN will also be publishing its annual Community Engagement Plan on its website in April 2013 to ensure transparency and accountability.

Areas of Engagement

Most engagement will involve health service providers as well as other health providers to ensure the availability of and access to appropriate health care services that improve the overall health of the population, which is consistent with the MH LHIN's vision of a seamless health system for our communities- promoting optimal health and delivering high-quality care when and where needed.

The LHIN will work to improve transitions, performance and reduce ALC, share best practices and common issues and maintain relations through Operational Sector engagement. Primary Care Physician engagement will also be a strong priority as we continue to build this relationship and Health Links are developed. The MH LHIN will continue to engage though various committees such as the Health Professionals Advisory Committee, and to seek input and convey information through engagement of MPPs, Mayors, Regional Chairs, Councilors and others. The ongoing Board to Board engagement will continue to reinforce the existing positive working relationships at the Governance level between the LHIN and its HSPs and amongst HSPs themselves.

As the LHIN sought to develop its new IHSP, feedback from over 1700 people was received to help direct the priorities of the tri-annual strategic plan. Over this year, the LHIN will continue to seek the views of residents throughout the year through various forms of engagement as it aims to be accountable to the people who were involved in developing the priorities.

eHealth

eHealth is a critical enabler to the Mississauga Halton LHIN's 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 in the cluster. This will be leveraged through 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.

Francophone Community

In carrying out community engagement under the Local Health Integration System Act (LHSIA) subsection 16(4), LHINs shall engage the Francophones and the French language health planning entity for its geographic area. The Francophone population in the MH LHIN consists of over 35,000 people under the new Inclusive Definition of Francophones (IDF). MH LHIN will continue its efforts to reach out to the Francophone community through different avenues such as *La Table de Concertation Francophone de Peel Halton et Dufferin*. In collaboration with the French Language Health Planning Entity, *Reflet Salvéo* (*Entité de planification pour les services de santé en français de Toronto Centre, Centre Ouest et Mississauga Halton)*, MH LHIN will be developing future community engagement events for its local Francophone community and for providers who offer services in French.

Aboriginal Community

The local Aboriginal community (First Nations, Métis and Inuit communities) in MH LHIN is 100 percent urban-based, as there is no reserve land or Indian Friendship Centres within our local territory. Like for Francophones, LHINs are mandated to engage the Aboriginal and First Nations communities and health planning entity for its geographic area. In the past, we have worked with providers and local community groups such as Peel Aboriginal Network, Métis Nation of Ontario, and Credit River Métis Council to hear about and address needs within the geographic area of the LHIN. We intend on continuing this relationship and build on the progress already made. MH LHIN will ensure that the Aboriginal Community is represented on engagement on topics such as Health Equity and Mental Health and Addictions.