

**Mississauga Halton Local
Health Integration Network
Annual Business Plan:
2018-2019**

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1) Context

A. Transmittal Letter

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Dear Ministry Colleagues,

On behalf of the Mississauga Halton LHIN, I am pleased to share with you the 2018-2019 Annual Business Plan (ABP), for Ministry of Health and Long-Term Care feedback. In addition to articulating how we will address priorities within Minister Eric Hoskins 2018-2019 mandate letter, this plan outlines new and ongoing initiatives for the third year of our 2016-2019 Integrated Health Service Plan and how we are supporting achievement of *Partnering for a Healthy Community*.

Transformation as a result of the *Patients First Act, 2016* sets an important context for our expanded LHIN mandate for this and future years. Post integration, a key priority for the Mississauga Halton LHIN remains building one high performing organization, so that we are well equipped to deliver on our system accountabilities to plan, fund and integrate the local health system, as well as provide care to the 48,000 individuals, and their families, who access LHIN-delivered home care services each year.

We are encouraged with the partnership opportunities before us –between the Mississauga Halton LHIN and the Ministry of Health and Long-Term Care, and between the Mississauga Halton LHIN and our system partners, including LHIN-funded health service providers, and key health stakeholders, including regional and municipal government, public health units, primary care providers and our residents.

Thank you for your continued support and partnership, and we look forward to receiving feedback on this annual business plan.

Sincerely,

Angie Burden
Vice President, Health System Strategy, Integration and Planning
Mississauga Halton LHIN

c. Bill MacLeod, CEO

B. Mandate (confirmation of the LHIN's mandate) and Strategic Directions

The Mississauga Halton Local Health Integration Network (LHIN) has a legislated leadership accountability through the *Local Health System Integration Act, 2006*, to plan, fund, and integrate the local health system, and through the *Patients First Act, 2016* to provide LHIN-delivered home care services within its defined boundaries. As a Crown agency of the Ministry of Health and Long-Term Care (MOHLTC), the Mississauga Halton LHIN works in collaboration with the MOHLTC, health service providers, key stakeholders and the community to improve the health care system for residents who live within our geographic boundaries. The *Patients First Act, 2016* provides for an expanded role for LHINs across the province, and presents the opportunity for LHINs to provide the required leadership to deliver locally on the Patients First vision, through intentional and collaborative planning and implementation partnerships.

The Mississauga Halton LHIN is guided by its mission, vision and values statements, as defined by its Board of Directors:

Mission

To lead health system integration for our communities

Vision

A seamless health system for our communities – promoting optimal health and delivering high quality care when and where needed

Values

Accountability | Holistic Approach | Innovation | Integrity | Respect | Partnership

The 2018-2019 LHIN ABP is the ninth ABP since the LHIN's inception in 2006. The 2018-2019 ABP identifies the activities that the LHIN will undertake in the upcoming fiscal year to achieve the strategic priorities articulated within the 2016-2019 Mississauga Halton LHIN Integrated Health Service Plan (IHSP) *Partnering for a Healthy Community*. This ABP represents the work to be undertaken within year three of the three-year strategic planning cycle of the current IHSP and forms part of the annual Ministry-LHIN Accountability Agreement (MLAA).

The LHIN's 2016-2019 IHSP was developed based on an extensive environmental scan and community engagement with local health service providers, external partner groups, patients, residents and caregivers. The plan reflects the voices of our citizens and what is needed to build a stronger system of care. It focuses on the needs of the diverse people living in our community, including our Francophone community residents and Indigenous residents. It builds upon the successes and lessons learned over the past 10 years and leverages the strengths of local leaders and partners.

In alignment with the Ontario government's priorities articulated in *Patients First: Ontario's Action Plan for Health Care*, the 2016-2019 IHSP *Partnering for a Healthy Community*, identifies the following three key strategic priorities:

ACCESS

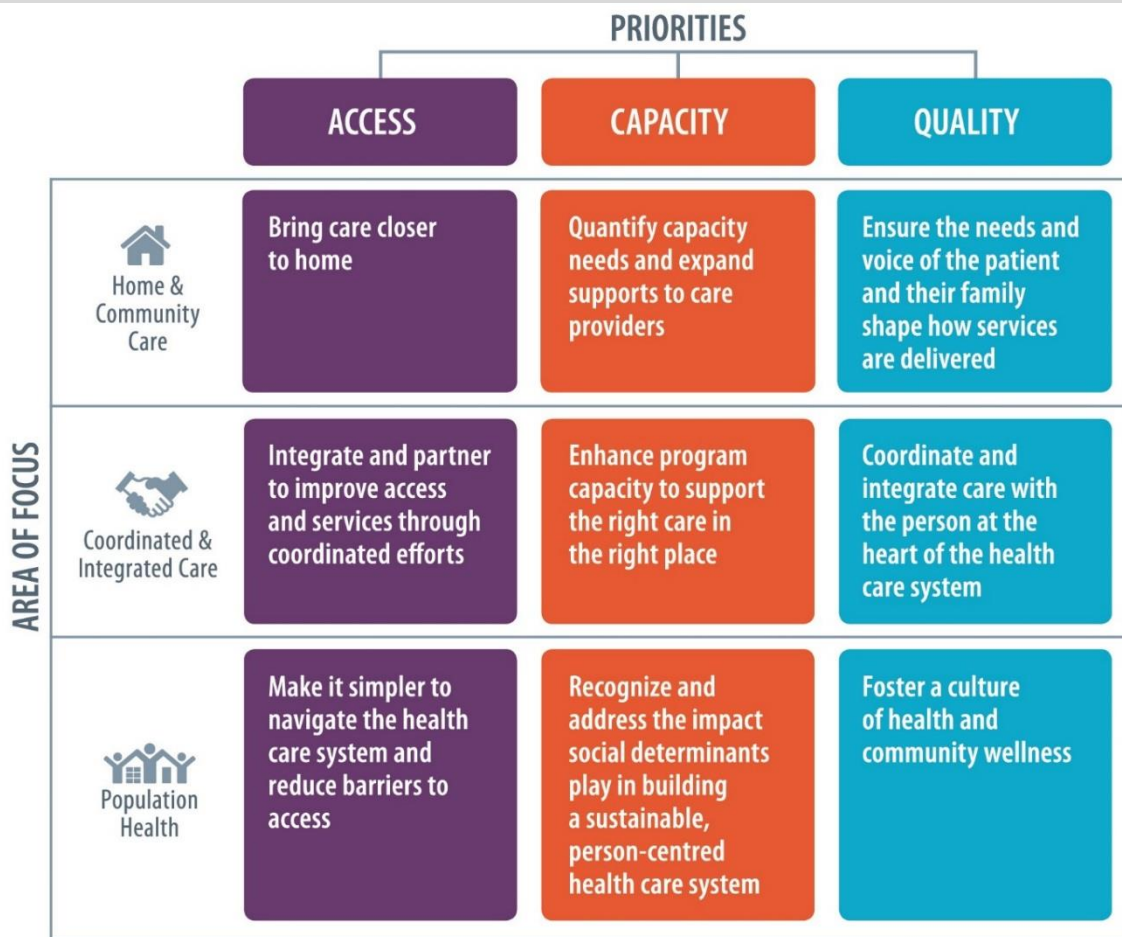
Health care when and where you need it

CAPACITY

Required resources, now and for the future

QUALITY

Positive person experiences and outcomes across the care continuum



These three priorities have been defined by specific goals and areas of focus:

Our key priorities, goals and areas of focus align with the Ontario government's four key objectives for putting patients first, specifically:

- **Access** - provide faster access to the right care
- **Connect** - deliver better coordinated and integrated care in the community closer to home
- **Inform** - provide the education, information and transparency that people and patients need to make the right decision about their health
- **Protect** - make decisions based on value and quality, to sustain the system for generations to come

In alignment with *Patients First: A Roadmap to Strengthen Home and Community Care*, and its new mandate to provide LHIN-delivered home care services, the LHIN continues to work towards improving access to quality health services in the community that are sustainable and delivered closer to home. Putting patients first, the LHIN strives to integrate and coordinate care with the patient at the centre, so that the health care system is simpler to navigate. As a merged organization, we will also progress towards changes required by the *Patients First Act, 2016* which bring primary care teams

under the umbrella of the definition of a health service provider and further build an integrated system.

We work to ensure that the needs and voice of patients, families and caregivers shape how services are delivered. The goal is to improve health experiences and foster a culture of health and community wellness. We are committed to addressing the impact of the social determinants of health through a collaborative, population health approach. Engaging with cross-ministerial partners and local key stakeholders is essential to support residents to live healthy lives.

We continue to move forward on accountability and transparency, advancing health system funding reform so that Ontario's health funding is fair and equitable and reflects what people need.

We believe our collective efforts identified in our IHSP, *Partnering for a Healthy Community*, support the local health care system to meet the needs of our citizens today and in the future, and that the action plans identified within this 2018-2019 ABP will support the achievement of our priorities.

As we make progress on our third and final year of initiatives within the 2016-2019 IHSP, we also embark on the development of a six year strategic plan that will inform two successive IHSPs. A part of our strategic planning efforts will be to develop a capacity plan to address MOHLTC priorities at the local level and make the best use of available resources to manage population health needs and achieve high quality health care and system sustainability. Informed by comprehensive consultation, patient and citizen engagement, health system collaboration and partnerships, this simultaneous work will set us on the path of innovation and cross-sectorial collaboration required to ensure that as a community, we realize the transformation for our local Mississauga Halton LHIN health system consistent with the *Patients First Act, 2016*. We invite you to join us.

C. Alignment with the Priorities of the Minister's Mandate Letter

Details of specific initiatives where applicable are provided in Sections 2 and 3:

Minister's 2018-2019 Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's 2018-2019 ABP	Overview
Transparency and Public Accountability	Performance Scorecard System (PSS)	The PSS is a LHIN system which the management of performance at the health system, sector and project level.
	Financial System Integration	The corporate financial systems support the effective use of and reporting on financial resources managed by the LHIN.
Improve the Patient Experience	Patient Engagement Strategy and the Patient and Family Advisory Committee	These initiatives ensure patients, caregivers, and families are involved in program and service development and evaluation to help improve outcomes and patient experience with our health care system.
	Expanded Caregiver Supports (Respite)	This project helps caregivers receive in-home support appropriate to their needs.
	Mississauga Halton Palliative Care Network (PCN)	The Mississauga Halton PCN is leading the development of a comprehensive patient-focused integrated and coordinated system of palliative care within the LHIN that is patient and family-focused.
	Regional Rehabilitative Care Strategy	Patients and families will benefit from increased access to an integrated, coordinated approach to rehabilitative care across the continuum. A key focus is increasing awareness of community based rehabilitation services and smooth transitions to improve the patient journey.
	Long-Term (Chronic) Mechanical Ventilation	This work is focused on creating the system capacity to support patients and families in prevention, early recognition and transitions from intensive care units, improving the quality of life for patients who are chronically ventilated.
	Emergency Respite: Creating and Improving System Partnership Plan	Patients and families will benefit through this work to establish a well understood pathway to emergency respite services.
	Supports for Daily Living (SDL) Leadership Committee Support	This initiative will investigate opportunities with home care services, community services and primary care to more effectively support clients with a higher level of need through LHIN partnerships and integration.
	Regional Quality Table (RQT)	The RQT is building a culture of quality

Minister's 2018-2019 Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's 2018-2019 ABP	Overview
		across the continuum of care within the LHIN and increasing regional capacity for quality improvement.
Build Healthy Communities Informed by Population Health Planning	Sub-region Conceptual Strategy/Framework	This work will lead to the development of an approach at the sub-region level for more integrated home and community care that addresses population health needs.
	Community Health Hubs	A regional strategy for community hubs that are LHIN implemented or supported is being created. A review of current state and various hub models, including consideration of the roles of the LHIN, municipal, and primary care system partners is in scope.
	Public Health	The LHIN will continue to build relationships with its municipal partners: Halton Region, Peel Region and the City of Toronto, and connect regularly on strategic planning, seniors' services, supportive housing, mental health and addiction, long-term care, chronic disease prevention and management, and community wellness.
	Regional Transportation System	The LHIN is working with transportation providers and community partners to develop and implement a solution for continued transportation service delivery and create a longer term plan for a regional transportation system.
	Residential Hospice Care (Capacity)	Work will continue with the MOHLTC and Heart House Hospice to advance the capital redevelopment of new hospice beds in the region.
	Acute Care Capacity Needs	The LHIN will continue to work collaboratively with hospitals and community partners to address hospital infrastructure needs and acute care capacity needs within the LHIN.
	Regional Food Security Strategy	A regional program for food security will be developed which will include central intake and expanding to other sectors for intake.
	Strategic Plan Development	A strategic plan is being created with system partners to inform two subsequent LHIN IHSPs covering the next six years. Our goal is a shared vision for health transformation amongst all health system leaders, and their organizations.

Minister's 2018-2019 Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's 2018-2019 ABP	Overview
Quality Improvement, Consistency and Outcomes-Based Delivery	Regional Quality Table	<i>See description earlier in the table.</i>
	Risk Event and Complaint Management System Renewal	The plan is to replace or upgrade the risk event and complaint management system.
	Wound Care Best Practices: Develop a Regional Wound Care Strategy and Implementation of Total Contact Cast (TCC) for patients with Diabetic Foot Ulcers (DFU) in Home & Community Care	The plan is to develop and implement a regional wound care strategy across the continuum of care. As well, the plan is to continue to expand clinic capacity and ongoing program enhancements to provide high quality care to patients with diabetic foot ulcers and pressure injuries.
	Health System Funding Reform	The LHIN's work continues to focus on quality-based procedure implementation and performance management of key indicators, such as wait times, length of stay, readmission rates and quality outcomes for patients.
Equity	Health Equity Plan	This work encompasses our approach to collective action to improve health equity and enable people living in the region – regardless of income, age, education, gender, sexual orientation, ethnicity or language – to have timely access to health care options. Health service providers will incorporate a health equity lens into their program planning and service delivery including use of the Ontario Health Equity Impact Assessment Tool. Regional health equity initiatives will be completed and sociodemographic data will be improved.
	Indigenous Cultural Safety Training	The LHIN will continue to offer online indigenous cultural safety training as part of its broader role in supporting positive health outcomes for indigenous people.
	French Language Services Joint Action Plan	This ongoing work is to implement LHIN specific elements and joint elements of a broader action plan to provide better access to French language services, inclusion of the Francophone voice at the sub-region level (focused on home and community care services) and an improved experience for Francophone patients.
Primary Care	Primary Care Integration (including expansion of inter- professional primary care teams and the Southwest Mississauga	Through this initiative, the LHIN will advance primary care integration. Activities include supporting the expansion of inter- professional primary care teams and

Minister's 2018-2019 Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's 2018-2019 ABP	Overview
	Community Health Care Hub)	developing, implementing and evaluating the model of primary care in the Southwest Mississauga Community Health Care Hub.
	Health Links	By continuing to evolve the Health Links approach – to a mature state that is aligning with sub-region activities, resourcing and planning – the LHIN will continue to improve coordination and integration of care for individuals with complex needs.
Hospitals and Partners	ALC Management	This initiative involves multiple partners and is taking a strategic approach to the management of alternate level of care issues within the LHIN, which contribute to constraints on hospital capacity for individuals with acute care needs.
	Bridges to Care	This program is for patients in hospital who no longer require acute care. They are provided with short-term enhanced community supports until they can transition to a long-term care (LTC) home or explore other options to remain in their home or a retirement home. Changes will be implemented based on the results of an evaluation currently underway.
	Integrated Funding Model (bundled care)	The LHIN will support Trillium Health Partners (THP) and Halton Healthcare to implement bundled care for hip and knee surgery in 2018-2019, while THP will continue to explore additional opportunities for integrated funding models.
	Community Paramedicine Program	Planned program expansion and implementation of the CP@Clinic model at social housing facilities with high 911 calls will focus on health promotion, reducing 911 calls, decreasing avoidable ED visits and facilitating the most appropriate care setting for seniors.
	Health System Funding Reform	<i>See description earlier in the table.</i>
Specialist Care	Rapid Access Clinics and Central Intake for Musculoskeletal Care	This work involves implementation of a shared care model and establishing central intake and assessment clinics for patients with hip and knee and lower back pain; the objective is to improve access to specialist care while reducing wait time.
	Central Intake Strategy	This initiative entails developmental work

Minister's 2018-2019 Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's 2018-2019 ABP	Overview
		around improvements in intake.
Home and Community Care	Neighbourhood Care Delivery Program of Work	This is a program of work with multiple spheres of activity which will improve home and community capacity at the neighbourhood level across the region.
	Mississauga Halton Palliative Care Network	<i>See description earlier in the table.</i>
	Mississauga Halton LHIN Palliative Program	This program will continue to deliver quality care for patients with palliative needs and their families and support them in their home environment until their last days of life – if that is their preferred choice of place to die. The LHIN will explore new models of care and continue its work to develop a regional MAID (Medical Assistance in Dying) process.
	Levels of Care Framework	The LHIN will implement local deliverables from the provincial Level of Care Framework initiative. The goal is to ensure consistent services and assessments across the province.
	Self-Directed Care	This project will ensure a successful Self- Directed Care Program is available for eligible patients in the region, built upon the provincial directed foundation.
	Special Needs Strategy for Children	Coordinated planning is continuing so that children with special needs and their families have the supports they need from the health, social services, and education sectors.
	Automated Provider Reporting	This project will focus on implementation of the new CHRIS feature for the LHIN and service providers.
	Home Care Assessment Modernization Project (local deliverables) – InterRAI	This project will ensure the LHIN adopts the provincial standard in electronic home care assessment tools.
	Wound Care Best Practices: Develop a Regional Wound Care Strategy and Implementation of Total Contact Cast (TCC) for patients with Diabetic Foot Ulcers (DFU) in Home & Community Care	<i>See description earlier in the table.</i>
	Risk Event and Complaint Management System Renewal	<i>See description earlier in the table.</i>
Long-Term Care	LTC Renewal	In alignment with the provincial LTC Renewal strategy, the LHIN is working to

Minister's 2018-2019 Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's 2018-2019 ABP	Overview
		enhance regional LTC physical and resource capacity, by maximizing the scope of practice and level of care to support transitions between sectors, exploring increasing the supply of LTC beds, and enhancing the role of LTC in the community through specialized programs and units within LTC homes.
	Integrated Seniors Care Model	A regional Integrated Seniors Care Model pilot project (PACE-like) to allow seniors to remain in the home of their choice is being implemented as an alternative to long-term care.
	Nurse Practitioner supports in LTC	This initiative will explore how nurse practitioners can work more collaboratively with the regional LTC sector.
	Palliative Care in LTC	The work includes implementing a palliative care framework with the regional LTC sector.
Dementia Care	Dementia Strategy	The Ontario Dementia Plan is designed to strengthen community care by meeting the needs and desires of people living with dementia. The Dementia Strategy will be implemented over the next three years. Initially dementia capacity planning will support the development and sharing of best practices across LHINs and support coordination and integration.
Mental Health and Addiction	Advance the Strategy to Prevent Opioid Addiction and Overdose	Additional psychosocial treatment capacity; community withdrawal management services; opioid use disorder peer support; mobile outreach of addiction supports into the community; and enhanced before-and-after care to prevent overdose deaths and promote prevention of relapse, are the focus of this initiative.
	Enhance Mental Health and Addiction (MH&A) Programs and Services	This initiative will enhance regional MH&A programs and services by expanding supports which enable equitable access to MH&A services (one-Link), ensuring the Sustaining Peer Supports Initiative measures the extent value-based peer work has been implemented in practice, advancing MH&A peer support services, and enabling four LHIN-funded MH&A agencies to participate in an advanced quality improvement

Minister's 2018-2019 Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's 2018-2019 ABP	Overview
		program. This work includes implementation of the No Wrong Door approach – Toward an “Every Door is the Right Door” service system, the development of standards for case management and data improvements.
Innovation, Health Technologies and Digital Health	Enabling Technologies for Integration	This local work supports the MOHLTC provincial digital health priorities as well as all four objectives (Access, Connect, Inform, and Protect) identified within <i>Patients First: Action Plan for Health Care</i> .
	Local e-Health Program of Work	This program of work is multi-faceted and is focused on providing appropriate information management and technology to LHIN programs and services on a priority basis in alignment with provincial initiatives.
	Health Links Care Coordination Plan Digital Solution Project (a.k.a. expansion of the use of the Care Coordination Plan via the Health Partner Gateway)	This project will result in expansion of the use of the care coordination plan via the Health Partner Gateway.
	Health Links Digital Support Strategy Development	This work will continue to focus on ensuring the Health Links approach is appropriately supported by digital solutions.
	Insights Platform Expansion	This work will result in the further expansion of a dashboard for leadership and care coordinators in LHIN Home & Community Care and Regional Programs portfolios.

D. Overview of the LHIN's Current and Planned Programs/Activities

Overview of Current Programs/Activities

Operating within an accountability framework defined in the Ministry-LHIN Accountability Agreement and guided by its IHSP 2016-2019 *Partnering for a Healthy Community*, the LHIN strives to ensure that health care dollars are spent efficiently and effectively, yielding the best results possible. Since May 31, 2017 the LHIN health system management accountability role has expanded to include the delivery of home and community care.

Within the LHIN, there are two public hospital corporations (six sites), 28 long-term care (LTC) homes (4,231 beds),¹ 32 community support service organizations, 10 mental health and addiction service providers and one community health centre. Each receive funding from the LHIN through formal service accountability agreements for the delivery of health care services (see table below). These agreements define the services to be provided and the outcomes to be achieved. Through the LHIN's relationships with these organizations and in concert with provincial efforts, the LHIN has continued to integrate and build regional capacity to meet a range of health care needs through initiatives related to the opioid strategy, dementia care, regional palliative care and patient transitions.

Mississauga Halton LHIN Health Service Provider Allocations – Nov. 30, 2017²

Health Service Organizations	# of Agencies	Total Funding (Base + One Time)	% of Total Funding
Hospitals	2 Corporations (6 sites)	1,060,209,137	74.8%
Long-Term Care Homes (LTCH)	28	208,119,005	14.7%
Community Support Services (CSS) *	32	94,692,089	6.7%
Mental Health and Addiction	10	43,722,646	3.1%
Community Health Centre	1	2,575,171	0.2%
Investments (unallocated as of January 31, 2016)	-	7,678,717	0.5%
TOTAL **	73	1,416,996,765	100.0%

*includes Assisted Living In Supportive Housing and Acquired Brain Injury

** the funding allocation to the legacy Community Care Access Centre (CCAC) is no longer included in this table as a result of its integration with the LHIN.

Seven Health Links have been established within the LHIN. As of October 2017, Health Links have served 2,858 individuals with complex needs within the LHIN. Nearly 60 per cent of these individuals have been identified as managing a mental health issue and 80 per cent of them have care coordination needs related to social determinants of health.

In 2018-2019 we will continue to evolve the Health Links approach to a mature state, fully aligning Health Links with sub-regions within the ministry's three year timeline. Our spread and scale of Health Links, and progression along the four domains of the Health Links Maturity Model will improve coordination of care for patients with complex needs and broaden the application of Health

¹ MOHLTC Long-Term Care Home System Report from New CPRO, August 2017.

² Source: MLPA, Schedule 3 - November 30, 2017 with adjustments.

Links to a wider population health approach. Expanded partnerships will provide greater support in advancing sub-region planning, service integration and performance improvement.

We are building the LHIN's primary care capacity to manage complex patients, focusing on primary care and home and community care integration, and the expansion of primary care inter-professional teams.

As part of our goal to make patients and families the centre of everything we do, we have a Patient and Family Advisory Committee consistent with the expectations of the *Patients First Act, 2016*.

The LHIN has forged solid relationships with its municipal partners of Halton Region and Peel Region, and the City of Toronto. Senior leaders and staff connect regularly on a number of fronts such as chronic disease prevention and management, inter-LHIN boundary issues, and community wellness along with others detailed in later sections of the document.

Our partnerships and integration efforts through LHIN-delivered home and community services are being offered to residents where the need is identified. We continue to make progress on the *Patients First: A Roadmap to Strengthen Home and Community Care* through anticipated implementation of self-directed care, the level of care framework, caregiver respite, bundled care, and greater choice for palliative and end-of-life care initiatives. The LHIN is working with home and community care providers to bring care closer to the people they serve by advancing sub-regions. Sub-regions allow for a better understanding of care patterns and diverse patient needs at a neighbourhood level.

The LHIN currently funds the Canadian Red Cross to coordinate and deliver community based transportation for individuals to access Adult Day Services, medical and dialysis appointments. Individuals are also able to access transportation services within the Mississauga Halton Region through a variety of community service providers, including non-profit agencies, Peel Region, Halton Region and private companies.

Excellence in digital health and technological innovation continue to underpin what we do and how we achieve success as an organization. We are making continual improvements with our partners through such initiatives as the e-Health Program of Work, telemedicine/telehomecare and Health Link digital supports.

Overview of Planned Programs/Activities

2018-2019 is the third year of implementing our 2016-2019 IHSP. We will build upon work completed in the previous two years and continue to advance our service system and delivery goals. Goals are derived from the IHSP's strategic priorities: *Access, Capacity and Quality* and set to align with the Minister's mandate letter.

For 2018-2019, we will work towards seven high level objectives. Highlights of how each objective will be realized are summarized below with details being provided in Sections 2 and 3:

1. *Patient and Family Engagement*: The *Patients First Act, 2016* ensures local communities and patients have a strong voice and influence local health care planning. In 2018-2019, the **Patient and Family Advisory Committee** will provide implementation guidance to a new Patient and

Family Engagement Strategy, to be launched April 2018, which will provide a framework to strengthen the foundation of patient and family engagement that exists within the LHIN.

2. *Integrate Home and Community Care and Primary Care:* The implementation of *Patients First: A Roadmap to Strengthen Home and Community Care* will be strengthened by adhering to the vision of the *Patients First Act, 2016*. We will build on our enhanced understanding and appreciation of neighbourhood based care, and in the new fiscal year, will further integrate home and community care into sub-regions through the **Neighbourhood Care Delivery Program of Work**. **Caregiver supports (respite)** will continue to be strengthened, and under ministry guidance, we will advance work on the **Levels of Care Framework, Self-directed Care** and the **Special Needs Strategy for Children**. As part of the **Sub-region Conceptual Strategy/Framework Initial Development** initiative, we will develop a sub-region conceptual framework to guide our work and broader system planning and further integrate and evolve **Health Links** into sub-regions. A key priority in 2018-2019 will be to continue to make progress in the **Primary Care Integration** work: so every resident who wants a primary care provider has one; to ensure that patients have timely access to those providers when they need it; and, to bring our primary care physicians into the partnership of health system planning and design.
3. *Improving Access and Flow:* We will continue our strategic approach through initiatives launched in 2017-2018, including the **Bridges to Care Program** and **ALC Management**. We will make further progress towards relieving system pressures and ensuring patients can transition seamlessly through the health care system, creating capacity to ensure that patients are cared for in the most appropriate setting that meets their needs. The **Rapid Access Clinics and Central Intake for Musculoskeletal Care** initiative will continue from the previous year to ensure gains in improved patient flow are sustained. To improve timely access to assessment and treatment options for hip, knee and lower back pain, the LHIN is developing Regional Rapid Access Centres and a Central Intake System for musculoskeletal care that will provide care closer to home and reduce wait times.
4. *Advancing Regional Programs:* In 2018-2019, patients with palliative needs and their families will be supported through the work of the **Mississauga Halton Palliative Care Network** and **LHIN palliative care services**. The provision of mental health and addiction services will be enhanced through regional action on the initiative: **Advance the Strategy to Prevent Opioid Addiction and Overdose**. We will continue to advance dementia care through local work in support of provincially directed **Dementia Strategy** goals. To meet the **acute care capacity** needs of the residents of the Mississauga Halton LHIN, we continue to advance the capital redevelopment of Trillium Health Partners and early planning is underway in Halton Hills to address infrastructure requirements of the Georgetown site. With our hospital partners, we continue to support innovative funding models by **bundling acute and post acute care** for procedures such as cardiac surgery and hips and knees. In support of the third mandate of the Rehabilitative Care Alliance, the LHIN continues to streamline access to timely, **integrated rehabilitative care** across the region with a key focus on improving access to integrated community based rehabilitative programs and services. To improve care for individuals with chronic conditions and enable care closer to home, the LHIN is developing **Community Paramedicine** programs across the LHIN. The **Regional Quality Table (RQT)** focuses on building capacity for quality in the LHIN's community health service providers offering numerous opportunities for education and training in quality improvement tools. The RQT also focused on fostering a quality improvement culture.

5. *Health System Development:* We will continue to work with a view to future planning for development initiatives that improve our local health system, including for example, understanding how **Community Health Hubs**, can be developed in neighbourhoods with enhancement opportunities, the various types of hubs needed and the role for community partners in developing hubs. We will explore how integrated primary care hubs can become the epicenter for learning, building communities of care and comprehensive care for patients and providers. Focus for this year will be to document current state, research best practice and make recommendations for future development.
6. *Build a High-Performing Organization:* This foundational work will ensure the LHIN continues its integration of organizational processes and systems so that we have the internal capacity to be effective in delivering our expanded mandate. This initiative encompasses work related to transparency, public accountability and quality such as the completion of **Workforce and Financial Information Systems Integration, Risk Event and Complaint Management System Renewal**, our **People Strategy** as well as the local **e-Health Program of Work** and further expansion of **Insights**, a dashboard for leadership and care coordinators in Home and Community Care and Regional Programs portfolios.
7. *Six Year Strategic Plan (2019-2025):* In 2018-2019, we will embark upon the creation of a **Strategic Plan** with system partners, which will inform the next two IHSPs for the LHIN. This strategic plan will be grounded in LHIN values, vision and mission, shaped by our cultural evolution, and will inform work the LHIN will undertake beyond March 2019 to deliver on Patients First transformation. Foundational to this planning will be a collective understanding that the 2019-2025 Strategic Plan serves as a roadmap both for the Mississauga Halton LHIN organization and the Mississauga Halton LHIN region. Our goal is a shared vision for health transformation amongst all health system leaders, and their organizations.

The LHIN will also benefit from the 2017-2018 **Health Service Provider Discretionary Fund** in 2018-2019. Four initiatives from the community sector are being funded in the areas of emergency respite, Indigenous holistic health and wellness, home and community care, and aphasia programming.

The LHIN is committed to ensuring a solid awareness and understanding of **health equity**, the social determinants of health and the effect these determinants have on health outcomes. To help our planning, programs and services to address the distinct, unique characteristics of our residents, the LHIN will apply a health equity lens as we strive to enable all people, regardless of income, age, education, sexual orientation, race, religion or language to have timely access to the health care options they require. Ensuring the voice of the patient and family are at the heart of our work is essential to driving the delivery of culturally and linguistically appropriate services and patient centred care.

Consideration for the social determinants of health and the impact they play in building a sustainable, person-centred health care system is another opportunity that the LHIN is looking to factor into program planning and service delivery to neighbourhoods with enhancement opportunities. This includes continuing to advance sociodemographic data collection with health service providers and other partners to help assess and evaluate the impact of a person's social determinants of health on outcomes. Sociodemographic data serves as a valuable resource to identify who and who is not accessing services, the effects of social factors on health outcomes

and increased awareness of potential barriers for underserved populations. Beyond providing a profile of health disparities, sociodemographic data is also a tool for aligning practices with unmet needs that enables health service providers to develop and track interventions, remove barriers and provide evidence-driven input for strategic planning.

E. Environmental Scan

A Diverse Population Demographic

With a population of approximately 1,292,831 residents (2017), the Mississauga Halton LHIN is home to 9.1 per cent of the population of Ontario. From 2017 to 2027, the LHIN is projected to have the second highest population growth in Ontario, increasing by 18.6 per cent in comparison to the provincial growth rate of 12.4 per cent for the same period.

The high population growth rate requires us to continually evaluate the capacity available within our acute and community resources to meet the needs of our residents. Seniors' health will remain a significant focus of health system improvement within the LHIN. While we currently have a relatively low proportion of seniors aged 65+ (13.8 per cent) relative to other areas of the province, by 2027, the population of seniors 65+ will increase by 57.8 per cent.

The Mississauga Halton LHIN has a wealth of culture due to its dynamic, diverse population demographic. Canadian newcomers account for 44.3 per cent of LHIN residents and nearly 41 per cent are visible minorities, compared to 25.9 per cent for Ontario. The top five visible minorities are South Asian, Chinese, Black, Filipino and Arab. In order to best serve these individuals, health service providers within the LHIN must explore opportunities to provide services in the most commonly spoken languages (beyond English): Urdu, Polish, Punjabi, Arabic and Portuguese.

English is identified by just over half (57.7 per cent) of Mississauga Halton LHIN residents as their mother tongue, while 1.8 per cent of the population identify French as their first language based on the 2016 Census. Approximately 25,000 Francophones reside within the LHIN according to the Inclusive Definition of Francophones (2011 Census). Indigenous residents make up 0.6 per cent of the population. The local Indigenous community (First Nations, Métis and Inuit communities) is urban-based, as there is no reserve land within the Mississauga Halton LHIN.

The 2011 Census is the most current data source at the LHIN-level. Population statistics will be updated when the 2016 Census profiles for LHINs are provided by the Health Analytics Branch (MOHLTC), planned for early 2018.

Complex Health Conditions

Over the last five years, the prevalence of chronic conditions and multiple comorbidities have increased and are slightly higher than the provincial averages. Mississauga Halton residents have experienced an increase in rates for arthritis, diabetes, high blood pressure and heart disease. The documented prevalence of diabetic foot ulcers (DFU) within the general population is 8 per cent,³ which translates to approximately 96,000 DFUs within the LHIN. Thirty-nine per cent of residents (aged 12+) have a chronic condition while 15 per cent have multiple conditions.

As noted across the province, the increasing prevalence of mental health and addiction issues is also reflected within the LHIN, with 26 per cent of residents reporting that most days are “quite a bit” or “extremely” stressful (third highest proportion in the province). Every year, one in every five, LHIN residents will develop a mental illness and/or addiction. While many will have relatively mild symptoms that pass with time, a change in their situation or treatment, two to three of every

100 residents will cope with a serious or complex mental illness and/or addiction throughout their lives.^{4,5,6,7,8,9,10}

Acute and Community Capacity Challenges

The Ontario Diabetes Discharge Database estimated rates of hospitalizations related to amputations in people with diabetes due to a DFU within the LHIN to be 326 per 100,000 people or approximately 3,912 in 2014/2015.¹¹ Hospitalization rates including emergency room visits for DFUs within the Mississauga Halton LHIN has been approximately 27 per 100,000 people, or 324 episodes in 2014/2015.¹² Additional data from Health Quality Ontario Health Technology Advisory Committee (OTACH) noted a revised prevalence rate of DFUs for the LHIN to be 9.5 per cent, translating to a projected number of 121,733 cases of DFUs in 2017.¹³

With our aging population and increased incidence of behavioural conditions related to dementia, there are capacity and operating expenditure pressures within our LTC homes. These pressures are compounded by the low ratio of LTC beds to population 75+, leading to the prioritization to admit only those residents with the highest acuity needs as identified by the MAPLe scores of residents. The Mississauga Halton LHIN actually has the lowest number of LTC beds per 1,000 people aged 75+ years at a rate of 55.8, which is also significantly lower than the provincial ratio of 76.2.

The profile of residents needing LTC has changed. The most frail and complex individuals are applying to LTC care homes. More than half of the residents in LTC are over the age of 85 years. Nine out of 10 individuals have some form of cognitive impairment with one in three being severely affected.¹⁴

There are approximately 500,000 individuals diagnosed with dementia in Canada with the prevalence expected to increase to 1.4 million by 2031 and 1.8 million by 2041.¹⁵ Currently in the

³ Mississauga Halton CCAC Wound care data 2016-2017.

⁴ Smetanin et al. (2011). *The life and economic impact of major mental illnesses in Canada: 2011-2041*. Prepared for the Mental Health Commission of Canada. Toronto: RiskAnalytica.

⁵ Government of Canada (2006). *The human face of mental health and mental illness in Canada*. Ottawa: Minister of Public Works and Government Services Canada.

⁶ Pearson, Janz and Ali (2013). *Health at a glance: Mental and substance use disorders in Canada*. Statistics Canada Catalogue no. 82-624-X.

⁷ Rush et al. (2008). *Prevalence of co-occurring substance use and other mental disorders in the Canadian population*. Canadian Journal of Psychiatry, 53: 800-9.

⁸ Canadian Institute for Health Information (2007). *Improving the health of Canadians: Mental health and homelessness*. Ottawa: CIHI.

⁹ Statistics Canada (2015). *Leading causes of death, total population, by age group and sex, Canada, 2012*. CANSIM 102-0561.

¹⁰ Bell Canada (2015). *Bell Let's Talk: The first 5 years (2010-2015)*. Retrieved from <http://letstalk.bell.ca/letstalkprogressreport>

¹¹ Ontario Diabetes Database, Discharge Abstract Database, Registered Persons Database, Ontario Health Insurance Plan provided by the Institute for Clinical Evaluative Sciences: Discharge Abstract Database, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO.

¹² Ibid.

¹³ Wound care Quality Standards Implementation Initiative Phase 1. Appendix A.

¹⁴ Source: Excerpted from [This is Long-Term Care 2016](#) by the Ontario Long Term Care Association. Data references are available in the report

¹⁵ Mapping Connections, Health Canada, 2014

Mississauga Halton LHIN various sources suggest there are less than 15,000 individuals residing in the community with diagnosed dementia.

Business Environment

The Mississauga Halton LHIN is continuing essential integration activities following May 31, 2017 when Mississauga Halton CCAC assets were transitioned to the Mississauga Halton LHIN. Significant progress has been made, and in 2018-2019 the focus will be on ensuring all transition and integration work is completed or is on track for completion to support a high-performing organization.

The LHIN works to ensure that patients with the most urgent needs are prioritized for access to acute care services and continues to explore innovative strategies. Acute care capacity continues to be an issue for the Mississauga Halton region as aging infrastructure coupled with significant population growth present challenges for the delivery of high-quality acute care services across the LHIN.

Our business environment and role in funding MOHLTC priorities ensures we continually seek out efficiencies while creating and improving our processes and encouraging the same in our system partners. We engage with public health units that cover the Mississauga Halton region to ensure our approaches consider health promotion strategies and those related to the broader determinants of health.

The integration and coordination of services for individuals of all ages with mental health and addiction issues often requires multiple stakeholders from across the continuum of health and social services to work collaboratively to address barriers to effective, timely care. These collaborations are time intensive and require a supportive environment to realize their potential to address common barriers to health, such as affordable housing and employment.

The business environment is increasingly technologically advanced. Both within the LHIN and across our partners there is a need to ensure health care providers have the capacity to take advantage of the investments in technology and that patients and families receive the desired benefits. The local eHealth program of work and the Enabling Technologies for Integration are linked to making progress on the ministry's 10-point digital plan.

Health Equity

The LHIN aims to actively involve patients, family and caregivers in the quality agenda and ensure that we embed health equity work systematically. Together we will enhance capacity by incorporating a health equity lens that will better inform program development and organizational outreach to marginalized groups while encouraging and maintaining health equity champions. The expectation is that our collective actions to improve health equity will result in measurable improvements in health outcomes for those populations in the Mississauga Halton region who are experiencing health inequities. By incorporating a health equity lens, we will continue to strive to enable all people, regardless of income, age, education, gender, sexual orientation, ethnicity or language to have timely access to the health care options that they require. Enhanced service responsiveness to the needs of marginalized populations, improved community collaboration and outreach to underserved populations will help to increase public awareness of services and allow for more discussions between providers, patients, families and caregivers to ensure their voices and needs are integrated into the care plan.

2) Health System Oversight and Management

PART 1: IDENTIFICATION OF PRIORITY - ACCESS

Priority

ACCESS

Priority Description

The Mississauga Halton LHIN will continue to work to reduce barriers and improve timely access to an integrated and coordinated health care system that focuses on improving transitions between sectors, strengthening home and community care and supporting individuals, particularly those with complex needs to navigate the health care system so they can receive the right kind of care when they need it.

Current Status

In 2018-2019 we will continue to evolve the **Health Links** approach to a mature state, fully aligning Health Links with sub-regions by 2020 as per MOHLTC requirements. The spread and scale of Health Links through the four domains of the Health Links Maturity Model will improve coordination of care for patients with complex needs, and broaden application of Health Links to a wider population health approach, and partners will demonstrate progress on these domains. The expanded partnerships will provide greater support in advancing sub-region planning, service integration and performance improvement. The Health Links approach and philosophy will be sustained and will serve as a foundation for coordinated care planning for all populations requiring coordination of care. Health Links will also address core competencies and provide training at a regional level as well as care conferencing. The 2018-2019 work will include selection and expansion of single solution for sharing Coordinated Care Plans (CCP) with system partners within the circle of care. Sub-regions (with application of the Health Links approach) will be supported digitally by the **Health Links Care Coordination Plan (CCP) Digital Solution Project** (realized through the CCP via Health Partner Gateway) and **Health Links Digital Supports Strategy** including use of local assets, such as local helpdesk, onsite technical support, and enhanced decision support techniques involving predictive modelling.

Through our **Primary Care Integration Strategy**, the LHIN continues to engage primary care to enhance collaboration and improved patient care, providing better access to primary care physicians and timeliness of care. Seven Clinical Leads have joined the LHIN; one for each sub-region. In partnership with the Primary Care Advisors and through other engagement, the Mississauga Halton LHIN submitted four business cases for the 2017-2018 funding year which targeted sub-regions with the lowest rates of team based primary care provincially. A new version of the existing Primary Care Database has been launched and is anticipated to continue to improve the ability to target requests to physicians and understanding the primary care landscape in terms of their needs, the distribution and areas of expertise. Supporting the implementation of funded Inter-professional Primary Care Team expansions and developing, implementing and evaluating the model of primary care in the Southwest Mississauga

Community Health Care Hub are part of next steps. Our Primary Care Network collaborative and its focus on collegiality, engagement and communications amongst physicians and between primary care and the LHIN, will be further enhanced. We will also explore the feasibility of implementing a Seamless Care Optimizing the Patient Experience (SCOPE) model to increase integration of care and decrease Emergency Department (ED) visits. Inter-professional Spine Education and Assessment Clinics (ISAEC) were launched in the LHIN this fall, enabling primary care providers to refer their patients for evidence-based care related to low back pain.

To improve equitable access and increase ease of navigation and **enhance mental health and addiction programs and services**, the LHIN continues to implement *one-Link*, a single point of access for referrals to LHIN funded and non-LHIN funded mental health and addiction service providers. The value of peer support to clients and families is profound, however, limited research exists for methodologies to enhance, quantify and evaluate this service. Work to improve peer support has been launched over the last year. The Community Addiction Liaison to the Emergency Department (CALED) continues to enhance transitions from hospital to the appropriate community support services for individuals and families identified with substance use conditions or concurrent disorders in the emergency department. Expansion of CALED includes improved alignment with crisis services continuum, implementation at an additional emergency department site and cross-emergency department data collection for review at the Addiction Services Expert Panel (ASEP) to inform program refinement and quality improvement opportunities. The No Wrong Door Champions Team continues to focus on best transfer protocols with a goal to ensure seamless transitions through the system for clients and families. one-Link data analysis provided information that in Mississauga Halton LHIN, high intensity programs and services were in greatest need leading to the development of a regional structured psychotherapy clinic. The High Intensity Community Services Review provided a current state landscape on which to begin to advance service improvements, integrate services and make key decisions on broad system change for case management and a regional minimal data set. Our work on crisis response is in development with discussions underway with Central West LHIN to help shape the eventual initiative. The LHIN has responded urgently to the opioid crisis by building service capacity for addictions treatment and supports as part of the initiative: **Advance the Strategy to Prevent Opioid Addiction and Overdose**.

The LHIN is working collaboratively with our Emergency Management Service (EMS) partners to develop a **community paramedicine program** that aims to meet the care needs of frequent emergency department users, recently discharged patients and/or at-risk patient population who lack access to primary care or community based service. In 2017-2018, the Halton EMS expanded CP@Clinic, a drop-in community based health promotion program that focuses on prevention of cardiovascular disease, diabetes and falls by providing assessments and health education, linking participants to community resources and reporting results to the participant's family physician. Planning is underway to identify opportunities to expand models of community paramedicine in 2018-2019.

To ensure access to health care when and where you need it, the LHIN is bringing care closer to home by focusing on specific **telemedicine solutions** that are readily available for adoption and spread. This year, the action plan will focus on the following five Telemedicine solutions: Video Visits, Telehomecare, eConsult, Teleophthalmology, and Enhanced Access to Primary Care (EAPC). These specific solutions have been presented to the LHIN by the Ontario Telemedicine Network (OTN) and our CEO is supportive of identifying both adoption and spread opportunities within our various programs. The expected outcomes include, but will not be limited to:

enhanced care coordination, improved patient wait times to specialists and allied health care providers, and increased as well as improved access to mental health and addiction support and care services. Aligned with our previous strategy, accessibility, knowledge and awareness will remain as foundational elements to any telemedicine solution implementations. This work will also support the creation of a virtual care platform in our Integrated Primary Care hubs with a focus on innovation.

Transportation is vital to ensuring people have access to essential health care services and supports. The former provider is no longer in a position to provide transportation as a core service, so the LHIN is working to develop alternative solutions to provide transportation. As such, the LHIN needs to identify how we can continue to offer this service to three priority users: adult day clients and medical and dialysis patients. Engagement of current transportation providers and all stakeholders will identify options for continued delivery and a longer term strategy that will identify gaps in service and enable a standardized, consistent, equitable and accessible regional transportation service for Mississauga Halton residents. A transition plan has been developed to ensure a smooth transfer of service for clients and stakeholders.

The LHIN's work within **Health System Funding Reform** continues to focus on quality-based procedure implementation and performance management of key performance indicators, such as improved access (wait time), length of stay, readmission rates and quality outcomes for patients. Trillium Health Partners' implementation of the **Integrated Funding Model** of cardiac surgery patients from hospital directly to the community has early evidence of a spreadable model of care. Other cohorts of patients that will undergo planning under a bundled model of care at Trillium Health Partners include: unilateral hip and knee surgery, surgical oncology and spine surgery. Halton Healthcare has also expressed interest in participating in the hip and knee bundle of care.

Improving quality, access and appropriateness of care for people with musculoskeletal conditions is a key priority of the LHIN. We will continue planning begun in 2017-2018, to expand central intake, assessment and management of hip and knee replacement surgery and low back pain management in the LHIN as part of the **Rapid Access Clinics and Central Intake for Musculoskeletal Care** initiative. This work will establish a common pathway for all patients with musculoskeletal conditions in need of specialist or specialty care.

Health service provider community discretionary funds will be used to support the **Supports for Daily Living Leadership Committee** to investigate opportunities and make recommendations to partner/integrate with home care services, community services and primary care to more effectively support clients with a higher level of need.

PART 2: GOALS AND ACTION PLANS

Goal (s)

As articulated within our IHSP, the following are the goals identified for Access – Health care when and where you need it:

Bring care closer to home

- Enable seniors and individuals with complex needs to live at home with appropriate in-home services
- Support seniors to stay in their homes by improving dementia supports and adult day programs
- Address transportation challenges by exploring innovative strategies with community partners
- Maximize the use of technology to connect providers and advance telemedicine home-based solutions to remotely monitor patient conditions and assist in self-management

Integrate and partner to improve access and services through coordinated efforts

- Foster good mental health and well-being throughout a person's lifetime by creating a more coordinated and integrated mental health and addiction system
- Increase coordination of care for individuals with complex needs by strengthening Health Links
- Improve access to family health care and specialist services
- Support transitions of care from acute care to the community by establishing seamless teams of providers across sectors through bundled care initiatives

Make it simpler to navigate the health care system and reduce barriers to access

- Identify and address barriers to access and enable person-centred, culturally appropriate health care delivery by fostering partnerships with community leaders
- Reinforce the capacity of health service providers to implement an Active Offer of French Language Services and keep the Francophone community informed of available French Language health care services
- Enhance understanding and awareness of health care system resources by simplifying and consolidating navigation tools

Government Priorities

The LHIN's strategic priority of Access – Health care when and where you need it, the above noted goals, as well as the action plans to support the achievement of these goals are consistent with the provincial government and Mississauga Halton LHIN priorities as reflected in:

- 2018-2019 Minister's Mandate Letter to LHINs (once forthcoming)
- Premier Kathleen Wynne's Mandate Letter to the Minister of Health and Long-Term Care
- *The Patients First Act, 2016*
- *Excellent Care for All Act, 2010*
- *Patients First: Action Plan for Health Care, 2015*
- *Patients First: A Roadmap to Strengthen Home and Community Care, 2015*

- *Patients First: A Proposal To Strengthen Patient-Centred Health Care In Ontario:* Discussion Paper, December 17, 2015
- *Patient Care Groups: A new model of population based primary health care for Ontario* (Price, Baker, 2015)
- *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy-Phase One and Phase Two*
- *Every Door is the Right Door-Towards a Ten Year Mental Health and Addictions Strategy* - A discussion paper
- *Taking Stock* - A report on the quality of mental health and addiction services in Ontario - HQO & ICES
- *Better Mental Health Means Better Health*, 2015 Annual Report of Ontario's Mental Health & Addictions Leadership Advisory Council
- *Mental Health and Addictions Moving Forward: Better Mental Health Means Better Health*, 2016 Annual Report of Ontario's Mental Health & Addictions Leadership Advisory Council
- *Health Canada Drug Treatment Funding Program Best Practices in Peer Support 2017* – Addictions and Mental Health Ontario
- Health Quality Ontario – Quality Standards for Major Depression, Schizophrenia, Opioid Use Disorder

Action Plans/Interventions

Action Plans		
	Expected Status (as of March 31, 2019)	Expected Completion Date
Action Plan 1: Continue to advance the Health Links approach to improve coordination and integration of care for individuals with complex needs by: a) Focusing on sustainability and scalability through progress on Health Quality Ontario's (HQO) four provincial maturity domains b) Addressing core competencies, regional training and care conferencing c) Increasing community capacity in managing complex patients including selection and expansion of single solution for the coordinated care plan with system partners within the circle of care and embedding the Health Links approach to care across sub-regions d) Engaging patients and caregivers effectively at every level of Health Links planning and decision making through the Patient and Family Advisory Committee e) Evolve Health Links approach to a mature state aligned with sub-region activities, resourcing and planning	In progress In progress In progress In progress In progress	March 31, 2020 April 30, 2018 March 31, 2020 Sept. 30, 2018 March 31, 2019
Action Plan 2: Advance the Mississauga Halton LHIN's Primary Care Integration strategy in alignment with the MOHLTC priorities related to the Integration of Primary Care and Home and Community Care: a) Support the implementation of 2017-2018 funded Inter-professional Primary Care Team expansions and 2018-2019 applications b) Develop, implement and evaluate the model of primary care in the Southwest Mississauga Community Health Care Hub c) Develop a primary care capacity plan d) Implement Inter-professional Spine Assessment and Education Clinics (ISAEC), a low back pain model of care e) Explore the feasibility of implementing a Seamless Care Optimizing the Patient Experience (SCOPE) model to increase integration of care and decrease ED visits f) Develop an eReferral platform for three targeted specialties to improve primary care access to specialist care by evolving our current docSearch platform g) Complete scoping for regional physician back office supports h) Build a physician health human resource	Complete In progress In progress Complete Complete In progress Complete In progress	March 31, 2019 March 31, 2022 March 31, 2020 March 31, 2019 March 31, 2019 March 31, 2020 March 31, 2019 March 31, 2019

strategy		
Action Plan 3: Enhance mental health and addiction programs and services: Key areas of focus for one-Link in 2018-2019 are expanded wait-list supports; self-management skills for clients and families; promotion and connection to peer supports, and Ontario Telemedicine Network (OTN) services; launch of the eReferral portal to primary care; and refinement of reporting capabilities to expand data capture, which includes sociodemographic data collection for effective population health based planning that is inclusive of social determinants of health. a) Enable equitable access to mental health and addiction services (one-Link) The Sustaining Peer Supports Initiative in 2018-2019 will measure the degree to which value-based peer work is implemented in practice, determined by the perception of and impact on people receiving peer services within LHIN-funded mental health and addiction services. b) Advance addiction and mental health peer support services In 2018-2019, four Mississauga Halton LHIN-funded mental health and addiction (MH&A) agencies are participating in an Advanced Quality Improvement Program to test change ideas and work toward a 30 per cent reduction target in no-show/did not attend rates. c) Implement the No Wrong Door approach – Toward an “Every Door is the Right Door” service system Expansion of the Community Addiction Liaison to the Emergency Department at an additional emergency department site and cross-emergency department data collection for review at the Addiction Services Expert Panel (ASEP) to inform program refinement and quality improvement opportunities. d) Define and develop addiction support services (Community Addiction Liaison to the Emergency Department Project) In 2018-2019, the Mississauga Halton LHIN will define and develop standards for case management across the mental health and addiction sector and develop a local minimum data set that will align the provincial data working group. e) High Intensity Community Services Review (LOCUS Level 3), Defining and Developing: Case Management and Minimal Data Set	In progress Complete Complete Complete Complete	March 31, 2022 March 31, 2019 March 31, 2019 March 31, 2019 March 31, 2019

partners has supported us in continuing to learn and understand population health and the specific nuances of our sub-regions. We have also focused on jointly identifying suitable locations for community hubs and plan collectively to support the health and wellness needs of local residents. The LHIN's efforts in addressing health equity have been strongly supported by our regional partners. Connections to primary care have also been coordinated using the LHIN's Primary Care Advisors as vehicles to support public health messaging. With the institution of the *Patients First Act, 2016*, the LHIN and regions continue to explore how to further strengthen our relationships and align our efforts to build a healthy community.

A **Sub-region Conceptual Strategy/Framework** is underway to support the development of sub-regions in the Mississauga Halton LHIN. This work is being done in alignment with the development of a maturity model for sub-regions at the provincial level. Sub-regions will focus on population health and the social determinants of health to create a network of health and social services providers working together to integrate care and improve the patient experience. This will include sub-region alignment with Home and Community Care and Primary Care and expanded access to inter-professional teams, as well as alignment with regional programs, such as mental health and addiction and palliative care.

An **Integrated Seniors Care Model** (PACE-like, based on elements from the Program of All-Inclusive Care for the Elderly (PACE) and other key strategies) has been developed to support the needs of a growing seniors' population in the LHIN, in particular those seniors at home waiting for long-term care and at risk of hospitalization and early placement into long-term care. PACE is a model of care that provides comprehensive medical and social services to frail, community-dwelling elderly individuals. A project team has helped design a pilot project that will commence in all likelihood as a co-location and program of the Southwest Mississauga Community Health Care Hub.

The Mississauga Halton Palliative Care Network (PCN) delivers on Ontario's commitment to hospice palliative care together with the Mississauga Halton Central West Regional Cancer program in partnership with Cancer Care Ontario and the LHIN. Our three-year strategic plan has been developed to support the Mississauga Halton PCN in providing leadership, direction and structure to facilitate the development of a comprehensive integrated and coordinated system of palliative care within the LHIN that is patient-focused. The Mississauga Halton PCN is focused on strengthening accountability, increasing access to integrated palliative care, and on engagement with and education of key stakeholders in the community including primary care, long-term care and patients and caregivers. This is all with the goal of improving the patient and family experience. The Mississauga Halton PCN is seeking to strengthen hospice and palliative care services for the homeless population within our LHIN and is participating in the Improving and Driving Excellence Across Sectors (IDEAS) Advanced Learning Program to improve access and understanding of advance care planning.

The Mississauga Halton LHIN Palliative Program continues to provide coordinated health care at home for one of our most vulnerable patient populations. The purpose is to deliver comprehensive, integrated, patient-driven, quality care for patients with palliative needs and their families and maintain them in their home environment until their last days of life – if that is their preferred choice of place to die. We have provided a new Enhanced End-of-Life Care Program in order to keep patients home and out of hospital or discharged from hospital earlier to die at home. The program is progressing towards collecting data and improving information related to

the Health Quality Ontario measure - dying in place of choice. The Medical Assistance in Dying (MAID) process was developed to support our patients, caregivers and staff.

Increasing capacity for **Residential Hospice Care** is being planned as part of capital redevelopment.

The **Regional Rehabilitative Care Strategy** is working to standardize and streamline rehabilitative care services across the LHIN. The LHIN is working with the Rehabilitative Care Alliance (RCA) of Ontario to implement initiatives across our hospitals, long-term care homes and community providers to ensure that eligibility, service standards and access to care can be standardized regardless of where the patient accesses the system. In 2017-2018, there was a focus on identifying service gaps within the community to help support patients discharged from the hospital and those in the community needing rehabilitative care. Identification of type of rehabilitative care needed within our sub-regions is underway to create or modify existing service delivery models. Health service provider community discretionary funds will support an aphasia program with one-time funds in 2018-2019. The **Halton-Peel Community Aphasia Program** is a not-for-profit organization that is comprised of two funded groups that run weekly. This includes both an introductory group and a conversation group for people with acquired communication disorders in the Halton and Peel regions of Ontario. The overall Aphasic Program objectives are to, meet the needs of individuals with acquired communication disorders by providing specialized programs and education about (but not limited to) aphasia and supportive conversation techniques.

Health service provider community discretionary funds will be used for the **Emergency Respite-Creating and Improving System Partnership Plan** which will increase access by establishing a well understood pathway to access emergency respite services and streamlining processes to transition clients within the spectrum of existing community respite services. A comprehensive review of emergency respite services identified an overall lack of these services and increasingly limited access to existing respite infrastructure due to high demand. System capacity will be enhanced to meet a wide and diverse range of patient needs. Moving forward, a formalized continuum of respite services will be established to meet emergency need, with community step-down capacity to meet urgent need, and on-going programs and services to provide ongoing support. By leveraging the strength, infrastructure, and respite provider expertise the needs of patients and caregivers will be prioritized.

The LHIN has been working collaboratively with hospitals and community partners to address the aging hospital infrastructure needs and **acute care capacity needs** within the LHIN. On October 1, 2017, the expanded Milton District Hospital opened officially with an increase in in-patient capacity from 63 beds to 129 beds. Halton Healthcare continues in the early stages of capital planning to redevelop elements of its aging facility at Georgetown. The LHIN continues to work with the ministry and THP to advance THP's redevelopment proposal for the Mississauga and Queensway sites, while construction is in the final stages at the Credit Valley site. Planning is also underway with Hope Place Centres to relocate and redevelop their residential treatment centre and consolidate all programs and services on one site.

The LHIN is in its second year of implementing a **regional food security strategy**, which includes central intake for all residents. The implementation has included assessing the existing Meals on Wheels clients; where the next phase includes expansion to other patient cohorts, such as hospital, community support services (CSS), community health centre (CHC) sector, and

MH&A. Further, standardized and centralized access to congregate dining will fall within this implementation. Finally, this implementation includes a portal, where more than 80 other community providers are represented, outside of health, to ensure that the most vulnerable of our residents have access to nutritious food. The refinement of an assessment tool continues working in conjunction with the University of Waterloo InterRAI consortium.

The Mississauga Halton LHIN Critical Care Network have established a **Long-Term (Chronic) Mechanical Ventilation (LTMV)** sub-working group with representation from Trillium Health Partners, Halton Healthcare, and the LHIN. The initiative is led by Dr. Janos Pataki, Mississauga Halton LHIN Critical Care Lead, in collaboration with a multi-disciplinary, inter-professional team that includes input from patients with lived experience. The LTMV sub-working group is committed to the development, implementation and evaluation of an evidence informed practice that supports seamless patient and family-centred care and improves the quality of life for the chronically ventilated patient.

Development of a longer term strategy for integrated **Community Health Hubs**, focused on neighbourhoods with enhancement opportunities will be initiated to understand the current state including roles. This initiative will lead to a cohesive regional strategy for community hubs that are LHIN implemented or LHIN supported. The scope will include design and development of a business model, if applicable.

As the proportion of the aging population continues to grow, the LHIN has a focus on meeting the needs of frail and complex seniors and building capacity through **LTC Renewal, Nurse Practitioner Supports in LTC, and Palliative Care in LTC**.

The community care of persons with dementia has historically been inadequate, which has resulted in avoidable hospitalizations and increased pressure particularly in the LTC and acute care sector. The Ontario Dementia Strategy is designed to strengthen the community care component by meeting the needs and desires of people living with dementia. The **dementia strategy** will be implemented over the next three years with investments in 10 key areas. To support the implementation of the dementia strategy, the MOHLTC has developed an approach to capacity planning to prioritize and allocate resources to meet the needs of the dementia population while meeting ministry objectives. Dementia capacity planning will support the development and sharing of best practices across LHINs and support coordination and integration. Evaluation of the strategic investments is a key component of the dementia strategy. As the LHIN's and health system partners implement their plans there will be monitoring and continuous improvement through the data collected as part of the strategy. This will enable both the LHIN and the ministry to monitor the progress and impact of the strategy and increase the understanding of the dementia populations to inform the planning work.

PART 2: GOALS AND ACTION PLANS

Goal (s)

As articulated within our IHSP, the following are the goals identified for Capacity – Required resources, now and for the future:

Quantify capacity needs and expand supports to care providers

- Quantify infrastructure and human resource needs and establish plans for capacity building through capacity planning in all sectors
- Empower caregivers by providing them with the supports, skills and optimal care for their loved one
- Enhance training and supports for personal support workers and other community providers
- Advance peer support initiatives and networks to leverage the expertise and knowledge of people with lived experience

Enhance program capacity to support right care in the right place

- Support individuals with the highest needs by exploring new models of care delivery for specialized care units when redeveloping long-term care homes
- Enable hospitals and community services to better coordinate care and shift resources from acute care to the community through joint strategic regional program planning
- Ensure people receive the care they need as they reach end of life through coordinated regional palliative care services
- Assist people's recovery and keep them healthy and active by improving coordination between the various levels of care for rehabilitation services
- Expand enhanced learning opportunities and specialist e-consults for primary care

Recognize and address the impact social determinants play in building a sustainable, person-centred health care system

- Meet the unique local needs of the community by working with partners to leverage existing assets and establish integrated community health hubs
- Support individuals in need of assisted living supports and affordable housing through collaboration with municipal partners
- Expand sociodemographic data collection and review to build the capacity of providers to assess and evaluate the impact of a person's social determinants of health

Government Priorities

The LHIN's strategic priority of Capacity – Required resources now and for the future, the above noted goals, as well as the action plans to support the achievement of these goals are consistent with the provincial government and LHIN priorities as reflected in:

- 2018-2019 Minister's Mandate Letter to LHINs
- Premier Kathleen Wynne's September 2016 Mandate Letter: Health and Long-Term Care. Premier's instructions to the Minister on priorities
- *Patients First Act, 2016*

- *Patients First: Action Plan for Health Care*, 2015
- *Patients First: A Roadmap to Strengthen Home and Community Care*
- *Living Longer, Living Well: Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a Seniors Strategy for Ontario*. Dr. Samir Sinha, December 20, 2012
- *Mississauga Halton LHIN Community Capacity Plan: Meeting Senior Care Needs Now and in the Future*, 2015
- *Palliative and End-of Life Care Provincial Roundtable Report*, John Fraser, March 2016
- *Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action*, December 2011
- *Palliative Care at the End of Life*, Health Quality Ontario, 2016
- *Developing Ontario's Dementia Strategy: A Discussion Paper*, September 2016
- *Levels of Care Framework: Reporting Back on What We Heard*, November 2016

Action Plans/Interventions

Action Plans		
	Expected Status (as of March 31, 2019)	Expected Completion Date
Action Plan 1: Support home and community care transformation and develop a Sub-region Conceptual Strategy/Framework at the sub-region level for more integrated home and community care that addresses population health needs. a) Develop and implement a sub-region planning framework b) Develop an integrated work plan in support of evolving sub-regions, part of which will be implemented	In progress In progress	March 31, 2019 March 31, 2019
Action Plan 2: Implement a regional Integrated Seniors Care Model (PACE-like) pilot project to support seniors to remain in the home of their choice.	In progress - pilot project implemented and evaluated	April 2019
Action Plan 3: Develop and implement a regional palliative care strategy through the Mississauga Halton Palliative Care Network in alignment with provincial directions: a) Develop a process for early identification of patients with palliative needs b) Work with the MOHLTC and Heart House Hospice to advance the capital redevelopment project for new hospice beds in our region Continue to advance the Mississauga Halton LHIN palliative program: a) Explore and identify new models of care to support patients with palliative needs in the community b) Development of a regional MAID program	Complete In Progress Complete Complete	Dec 2018 Dec 2020 March 31, 2019 March 31, 2019

Action Plan 4: Develop and implement a sustainable regional rehabilitative care system that spans the care continuum and follows the patient journey while improving patient experience and provider processes. a) Alignment with the Rehabilitative Care Alliance of Ontario in implementing standard provincial initiatives across the LHIN b) Identifying rehabilitative care/service gaps within the community to improve access and flow from acute to post-acute or within post-acute (community) c) Improving care planning and patient experience by identifying standard information needs to be shared with providers across the care continuum d) Working with other regional and local initiatives to improve rehabilitative care connections within the LHIN, such as implementation of a central intake musculoskeletal model	In progress	March 2020
Action Plan 5: Increase access by establishing a well understood pathway to access emergency respite services including: a) Hiring of coordinator to oversee and develop plan for optimization of Nora's House b) Establishing of Emergency Access pathway to Nora's House c) Establishing a data set to support improvements to access, capacity and quality d) Quarterly reporting on data set	Complete Complete Complete Complete	March 31, 2019 March 31, 2019 March 31, 2019 March 31, 2019
Action Plan 6: a) Continue to address acute and community capacity needs and work collaboratively with the ministry, primary care, hospitals and community providers to advance capital infrastructure projects within the LHIN b) Continue to develop a regional program for food security, including central intake, expanding to other sectors for intake, such as hospital, and other CSS, MH&A, CHC sectors in the LHIN c) Continue to develop a regional chronic mechanical ventilation strategy that will support transition from hospital to community and improve the quality of life for the chronically ventilated patient while providing care at the right place	In progress In progress Complete	2026 March 2020 June 2019

	Action Plan 7: The community health hub initiative will include: a) Review current state and various hub models under consideration or implemented b) Define roles, e.g., LHIN, municipal, primary care, system partners c) Develop/align a regional strategy for community hubs	Complete	March 31, 2019
		Complete	March 31, 2019
		Complete	March 31, 2019
		Complete	March 31, 2019
	Action Plan 8: In alignment with provincial Dementia Strategy capacity planning: a) Establish a Mississauga Halton LHIN Dementia Capacity Planning Table b) Draft a Mississauga Halton LHIN Dementia Capacity Plan using the ministry capacity planning tool and regional profile tool that will enable: i. An understanding of the LHIN needs on dementia and capacity issues ii. Inform relevant ministry initiatives and policy decisions c) Identify the measures of success as they relate to the implementation of the Mississauga Halton LHIN Dementia Capacity Plan d) Develop and monitor indicators of success	Complete	March 31, 2019
		Complete	March 31, 2019
		Complete	March 31, 2019
		Complete (ongoing)	March 31, 2019
	Action Plan 9: In alignment with provincial LTC Renewal strategy, enhance the physical and resource capacity within the LTC sector by: a) Maximizing the scope of practice and level of care to support transitions between sectors b) Exploring opportunities to increase supply of LTC beds c) Enhance the role of LTC in the community through the addition of specialized programs and units within LTC homes d) Development and implementation of a palliative care framework.	In progress	March 2020

PART 1: IDENTIFICATION OF PRIORITY – QUALITY

Priority

Quality

Priority Description

A high-quality health system is defined in the *Excellent Care for All Act, 2010* as “A health system that delivers world-leading safe, effective patient-centred services, efficiently and in a timely fashion, resulting in optimal health status for all communities.” In alignment with this vision, the Mississauga Halton LHIN is building upon the existing work of our health service providers to promote a culture of quality and recognizes the value of learning from the experiences of patients, families and caregivers to guide continuous quality improvement and improved health outcomes. People value their health and want to remain as healthy as they can. We want the positive experience people gain from the health care system to not only help them when they are ill, but also support them to stay healthy and prevent disease.

Current Status

A health care system for the people is best built by the people that use it. The LHIN understands that having patients, caregivers and families involved in the development of programs and services, as well as decision making, is important in improving outcomes of personal experience within our health care system. The perspectives they share not only help guide our work, but their experiences, stories and insights also serve as an important measure when evaluating the success of our various projects and initiatives.

As we continue to build our **patient and family engagement program**, learning how best to incorporate the voice of patients, caregivers and families into all aspects of our work, we have recently established a regional **Patient and Family Advisory Committee (PFAC)**. The PFAC serves as an advisory committee to the LHIN and is comprised of individuals with lived-experiences in the various health sectors, as well as geographically, and culturally diverse groups across our LHIN. Committee members are currently partnering with us as we co-develop a patient and family engagement strategy to guide the LHIN on a regional approach for the engagement of patients and families in health system planning and improvement. Mississauga Halton LHIN efforts will build upon existing efforts to engage patients, families and individuals with lived experience, and complement existing forums.

Building on the momentum already established with the Health Equity Sociodemographic Data Collection Project, we will continue to focus on improving **health equity** and providing high quality person-centred care. The project aims to build the capacity of health service providers by ongoing and sustainable training and support in standardized collection and analysis of sociodemographic data, as well as training on the implementation of the Health Equity Impact Assessment (HEIA) tool. The HEIA tool supports the development of quality improvements, more equitable health program and service delivery, greater system access, more diverse programming for comprehensive care and a better patient, family and caregiver experience. Focusing on the most vulnerable populations, supporting the provision of services which are

linguistically and culturally competent, and working with **Indigenous leaders** and the **French language health planning entity**, Reflet Salvéo, we will continue to leverage existing capacities and explore new opportunities to ensure equitable health care for all.

The LHIN **Regional Quality Table (RQT)** is in its second year of advancing the quality agenda within the LHIN. The membership consists of representatives from all health sectors and from initiatives such as Health Links, cancer care, palliative care and the Community Quality Network. In partnership with Health Quality Ontario, we continue to focus on aligning quality initiatives across the continuum of care to improve patient outcomes, experience of care and value for money. The RQT is focused on LHIN quality challenges and initiatives, and is in the final stages of approval for its integrated regional quality improvement plan (IRQIP). The focus of the IRQIP will be on seamless transitions between hospital and home and implementation will start in February 2018 and continue through 2018-2019. The RQT will continue to focus on building the capacity and culture for quality in the LHIN's community health service providers offering numerous opportunities for education and training on quality and quality tools.

Under the oversight of the RQT, the LHIN will continue to host the annual LHIN-wide Quality Awards Event and for 2018-2019 will be adding a day-long regional quality forum.

The RQT, along with a unified quality improvement goal of transitions in care across all sectors, will support the provision of high quality care across the LHIN. Quality is being integrated into how care is improved in multiple ways including: promoting quality improvement in primary care through partnerships with Centre for Effective Practice, working with Health Quality Ontario and using our team of primary care advisors and primary care leads in opportunities such as the Primary Care Clinic Day and fostering a quality culture in the integrated primary care team expansion.

PART 2: GOALS AND ACTION PLANS

Goal (s)

As articulated within our 2016-2019 IHSP, the following are the goals identified for Quality – Positive person experiences and outcomes across the care continuum:

Ensure the needs and voice of the patient and their family shape how services are delivered

- Be inclusive of people's circle of support in the planning and provision of care delivery models

Coordinate and integrate care with the person at the heart of the health care system

- Involve people with lived experience as active team members on program development or quality improvement committees by utilizing experience based design
- Drive the delivery of culturally and linguistically appropriate services by engaging with and listening to the voices of Indigenous, Francophone, and other community groups
- Support people to find the care that fits their needs by fostering a no wrong door culture
- Develop models for positive patient experiences by learning from industries that excel in customer service

Foster a culture of health and community wellness

- Explore joint opportunities to promote healthy living and optimal health by collaborating with community partners
- Apply a health equity lens for program development and health care service delivery
- Develop a quality framework that includes measures related to care outcomes and people's experience with the health care system

Government Priorities

The LHIN's strategic priority Quality – Positive person experiences and outcomes across the care continuum, the above noted goals, as well as the action plans to support achievement of these goals are consistent with the provincial government and LHIN priorities as reflected in:

- 2018-19 Minister's Mandate Letter to LHINs
- Premier Kathleen Wynne's September 2016 Mandate letter: Health and Long Term Care. Premier's instructions to the Minister on priorities
- *Patients First Act, 2016*
- *Patients First: Action Plan for Health Care, 2015*
- *Excellent Care for All Act, 2010*
- *Quality Matters: Realizing Excellent Care for All*
- Health Quality Ontario Common Quality Agenda
- *French Language Services Act, 1986*
- Pan-LHIN Indigenous/First Nations priorities
- Provincial Health Equity Impact Assessment Tool
- International Association of Public Participation (IAP2)
- Health Quality Ontario Patient Engagement Framework
- CIHI Report: *Dialogue to Advance the Measurement of Equity in Health Care*
- *Health Quality Ontario's Health Equity Plan*
- *Health Quality Ontario's Income and Health; Opportunities to achieve health equity in Ontario*
- *Honouring the Truth, Reconciling for the Future* - Truth and Reconciliation Commission of Canada
- San'yas Indigenous Cultural Safety (ICS) Training - Ontario

Action Plans/Interventions

Action Plans			
		Expected Status (as of March 31, 2019)	Expected Completion Date
Action Plan 1: Develop and implement a regional LHIN patient and family engagement strategy :			
a)	Establish the Mississauga Halton LHIN PFAC	Complete	March 31, 2019
b)	Work with the committee to co-develop a regional roadmap for patient and family engagement strategy	Complete	April 1, 2018

c) Develop and implement processes, policies, tools and materials as Mississauga Halton LHIN infrastructure to support participation of patients and families	Complete	March 31, 2019
d) Implement a Mississauga Halton LHIN engagement strategy	In progress	March 31, 2021
Action Plan 2 Encourage and support providers, regional leaders and planners to increase knowledge and bring an equity focus to their work: a) Health service providers will adopt and incorporate a health equity lens into their program planning and service delivery including use of the Ontario Health Equity Impact Assessment (HEIA) Tool b) Regional Health Equity initiatives include: i. Annual Health Equity Symposium ii. Focused Implementation Sites iii. Education and training in sociodemographic data collection and analysis iv. Participation in health equity education through the Regional Learning Centre v. Centralize, collect and report on sociodemographic data	Complete	March 31, 2019
Action Plan 3: Undertake: a) Offer online training opportunities in Indigenous Cultural Safety	Complete	March 31, 2019
Action Plan 4: Implement LHIN specific elements and joint elements of the 2017-2019 French Language Services Joint Annual Action Plan (JAAP) (alongside Reflet Salvéo, Central West LHIN and Toronto Central LHIN) with the following objectives: a) Increasing access to primary care French language services at the sub-region level b) Inclusion of the Francophone voice at the sub-region level to help facilitate increasing home and community capacity resources for French language services c) Improving the Francophone patients' experience	Complete	March 31, 2019
Action Plan 5: We will continue to build a culture of quality across the continuum of care by implementing the Regional Quality Table's integrated regional quality plan to improve patients' transition of care between hospital and home and continue to build the capacity for quality improvement across the region	In progress	On-going
Action Plan 6: Engaging providers in a culture of quality care	In progress	On-going
Action Plan 7: Fostering innovation through identification of improvement opportunities	In progress	On-going
Action Plan 8: Adoption of best practices	In progress	On-going

3) LHIN-Delivered Home and Community Care

This is a time of great opportunity for positive change at the LHIN. Under the *Patients First Act, 2016* the transition of home care services and staff to the LHIN in May and June 2017 was a structural system change led by the Government of Ontario, designed to help patients and their families get better access to a more local and integrated health care system, including LHIN delivered home and community care services. We work closely with primary care providers, inter-professional health care teams, hospitals, public health units, mental health and addiction agencies, home care and community support service providers, to be able to better communicate and share information to ensure smoother patient experiences throughout the health care system. Our priorities are shaped by the current IHSP as outlined in Section 2.

PART 1: IDENTIFICATION OF PRIORITY – ACCESS

Priority

ACCESS

Priority Description

The Mississauga Halton LHIN will continue to work to reduce barriers and improve timely access to an integrated and coordinated health care system that focuses on improving transitions between sectors, strengthening home and community care and supporting individuals, particularly those with complex needs to navigate the health care system so they can receive the right kind of care when they need it.

Current Status

Through the **ALC Management** initiative we have been working with partners in our region and the MOHLTC to identify opportunities to ensure hospital care is reserved for patients who need it most. To best support patients and families in our region there is a need to address the high number of people who are appropriate for an alternate level of care (ALC) but remain in hospital beds designated for acute care patients. We continue to implement a three-pronged approach focused on:

1. Identifying at-risk patients in the community to prevent hospital admission and emergency department (ED) visits
2. Identifying patients in the ED and during their early part of the acute care stay at risk for ALC
3. Transitioning existing ALC Patients from hospital to the community or to long-term care

The **Bridges to Care Program** targets patients in hospital who no longer require an acute level of care (e.g. patients who have been identified as ALC). We provide short-term, enhanced community supports to patients for up to 60 days, including a dedicated care coordinator and placement care coordinator, after which time they will transition to a long-term care home or explore creative options for remaining in a personal dwelling or retirement home with in-home supports. We have increased our total number of beds to 16 and have added two new community support service providers who also offer access to patients to adult day programming during their

enrollment in the Bridges to Care program.

PART 2: GOALS AND ACTION PLANS

Goal (s)

As articulated within our IHSP, the following are the goals identified for Access – Health care when and where you need it focused on the delivery of home and community care services:

Bring care closer to home

- Enable seniors and individuals with complex needs to live at home with appropriate in-home services
- Maximize the use of technology to connect providers and advance telemedicine home based solutions to remotely monitor patient conditions and assist in self-management
- Bring care to the community or offer care in-home for those who are house bound by exploring mobile programs

Integrate and partner to improve access and services through coordinated efforts

- Increase coordination of care for individuals with complex needs by strengthening and embedding Health Links approach to care.
- Support transitions from acute care to the community by establishing seamless teams of providers across sectors through bundled care initiatives

Make it simpler to navigate the health care system and reduce barriers to access

- Identify and address barriers to access and enable person-centered, culturally appropriate health care delivery by fostering partnerships with community leaders
- Reinforce the capacity of health service providers to implement an Active Offer of French Language Services and keep the Francophone community informed of available French Language health care services
- Enhance understanding and awareness of health care system resources by simplifying and consolidating navigation tools

Government Priorities

- *Patients First: Action Plan for Health Care*, 2015
- *Excellent Care for All Act*, 2010
- 2018-2019 Mandate letter: Health and Long Term Care
- *Patients First, Act 2016*
- *Patients First: A Roadmap to Strengthen Home and Community Care*, 2015
- Levels of Care Framework : *Patients First: A Roadmap to Strengthen Home and Community Care*, 2015

Action Plans/Interventions

Action Plans		
	Expected Status (as of March 31, 2019)	Expected Completion Date
Action Plan 1: Implementation of the 2018-2019 deliverables of the ALC Management initiative building on the initial results and longer term plan in development in 2017-2018	Complete	March 2019
Action Plan 2: Implement changes based on the evaluation results of the Bridges to Care Program (to be completed May 2018)	In progress	March 2019 (next steps in part dependent on evaluation results)

PART 1: IDENTIFICATION OF PRIORITY – CAPACITY

Priority

CAPACITY

Priority Description

The Mississauga Halton LHIN will continue to work to identify new and innovative strategies to ensure the appropriate resources (funding, health human resources and infrastructure) are available and used efficiently to meet the needs of our growing and aging population, now and in the future. Building upon the recommendations in *Mississauga Halton LHIN Community Capacity Plan: Meeting Senior Care Needs Now and in the Future, 2015* and work underway in hospital capital and program planning, we will continue to quantify and address the pressures within our region and leverage our community resources to build a sustainable, person-centred health care system.

Current Status

The **Neighbourhood Care Delivery Program of Work** is encompassing

- Coordinated care planning implementation
- Care coordination optimization project (list of recommendations)
- Flex care model implementation project (home care providers)
- Nursing/interdisciplinary clinic expansions project
- Sub-region level organizational design work project (Home and Community Care)
- Practice validation Phase 2 project
- Suicide risk assessment project

This work is being aligned with sub-regions and we will continue to build from successes in 2017-2018.

Over the past several years, we have expanded **Caregiver Supports (Respite)** in keeping with

the Patient's First – Roadmap to Strengthen Home and Community Care. Work has progressed well and has seen a steady increase in the number of caregivers served since its launch. From the start of the program (mid-November 2016) to November 30, 2017 we have had 1,589 assessed caregivers and 1,523 caregivers authorized for service. As of November 30, 2017, 696 caregivers were receiving in-home respite. We are monitoring the utilization rate of the program and making adjustments as needed to ensure invested dollars are used wisely in Phase 2 of this project.

PART 2: GOALS AND ACTION PLANS

Goal (s)

As articulated within our IHSP, the following are the goals identified for Capacity – Required Resources, Now and For the Future focused on the delivery of home and community care services:

Quantify capacity needs and expand supports to care providers

- Empower caregivers by providing them with the supports, skills and optimal care for their loved one
- Enhance training and supports for personal support workers and other community providers

Enhance program capacity to support right care in the right place

- Enable hospitals and community services to better coordinate care and shift resources from acute care to community through joint, strategic regional program planning
- Assist people's recovery and keep them healthy and active by improving coordination between the various levels of care for rehabilitation services

Recognize and address the impact social determinants play in building a sustainable, person-centred health care system

- Guide service delivery to neighbourhoods with enhancement opportunities, identified based on cross-sectorial review of social determinants of health

Government Priorities

- *Patients First: Action Plan for Health Care, 2015*
- *Excellent Care for All Act, 2010*
- 2018-19 Mandate letter: Health and Long Term Care
- *Patients First Act, 2016*
- *Patients First: A Roadmap to Strengthen Home and Community Care*

Action Plans/Interventions

Action Plans		
	Expected Status (as of March 31, 2019)	Expected Completion Date
Action Plan 1: Develop and implement a roadmap from The Neighbourhood Care Delivery Program of Work , building from 2017-2018 deliverables	In progress	March 31, 2019
Action Plan 2: Caregiver Supports Respite will focus on ensuring caregivers are appropriately supported with respite care building upon utilization analysis from the 2017-2018 work plan.	In progress	March 2020

PART 1: IDENTIFICATION OF PRIORITY – QUALITY

Priority

QUALITY

Priority Description

A high-quality health system is defined in the *Excellent Care for All Act, 2010* as “A health system that delivers world-leading safe, effective patient-centred services, efficiently and in a timely fashion, resulting in optimal health status for all communities.” In alignment with this vision, the Mississauga Halton LHIN is building upon the existing work of our health service providers to promote a culture of quality and recognizes the value of learning from the experiences of patients, families and caregivers to guide continuous quality improvement and improved health outcomes. People value their health and want to remain as healthy as they can. We want the positive experience people gain from the health care system to not only help them when they are ill, but also support them to stay healthy and prevent disease.

Current Status

The following initiatives are part of our commitment to implement the Ministry’s priorities for home and community care outlined in the *Patients First: A Roadmap to Strengthen Home and Community Care*.

Levels of Care Framework: This initiative will be designed around provincial direction and will be implemented according to ministry requirements.

Self-Directed Care (SDC): We are building upon earlier work which advanced the strengthening of home and community care as an initial review, in expectation of further ministry direction, had suggested we could improve the process for patients receiving or interested in SDC agreements as an interim measure. This allowed a select group of patients and families to receive their own funding, based upon assessed need from the care coordinator, to

purchase services from a provider(s) of their choice. This success has positioned us well to take up new work as part of the new provincial program which will be launching in December 2017.

Special Needs Strategy for Children: Coordinated service planning has been underway with the development of common tools and processes and implementation of care coordination as of September 2017. Integrated rehabilitation is another component of the strategy which is continuing to unfold. We have also created a new care model for children with medical complexity and are continuing to refine this model. Our approach throughout has been and will continue to be one of collaboration with our regional and provincial partners both in health care, social services, and education sectors to help ensure a sustainable approach to this complex but important change for children with special needs.

Automated Provider Reporting is enabling a feature in CHRIS to further automate and enable the LHIN and service providers to work together to facilitate communications between their individual systems creating increased integration of systems and efficiencies.

The **Home Care Assessment Modernization Project (local deliverables) – InterRAI** is a project led by Health Shared Services Ontario (HSSOntario) to transition the LHINs' from the RAI-HC to the InterRAI HC. HSSOntario is supporting the Mississauga Halton LHIN to prepare our staff for the transition. This includes change management, education for front-line staff, and adaption of data and reporting functions.

The impact on lifestyle changes for patients diagnosed with diabetes is a significant one. Without alterations to diet, exercise, smoking, foot care and proper offloading, the progression of this disease can lead to limb amputation, the psychosocial effects of amputation and ultimately death.

The **Wound Care Best Practices: Develop a Regional Wound Care Strategy and Implementation of Total Contact Cast (TCC) for patients with Diabetic Foot Ulcers (DFU) in Home & Community Care Project** will result in a sustainable process that allows for equitable access to the gold standard in off-loading, Total Contact Cast (TCC), for appropriate patients with diabetic foot ulcers (DFU). Standard wound care has a closure rate of 40-50 per cent¹⁶ compared to TCC, which has been shown to heal 90 per cent of DFUs within six weeks.^{17,18} TCC application is occurring in a clinic setting only. Six LHIN clinics and the associated service provider partners will be participating in a staggered implementation. This work along with a regional adoption of the HQO wound care standards across Home and Community Care, Long Term Care, Hospitals and Primary care is aligned with the wound care indicators in the 2018-2019 HQO Quality Improvement Plan (QIP).

Risk Event and Complaints Management System Renewal is being implemented in 2018-2019. As the current LHIN Risk Event and Complaints Management System is out of date and no longer technically supported, we will be evaluating options for upgrade or replacement and implementing the change starting the first quarter of 2018-2019. The plan is to implement a comprehensive system that reports and manages patient and staff risk events, home and community care complaints, as well as health service provider complaints and enables enhanced

¹⁶ Margolis D, Kantor J, Berlin J. Healing of Diabetic Neuropathic Foot Ulcers Receiving Standard Treatment. *Diabetes Care* 1999;22:692.

¹⁷ Armstrong DG, et al. Off-loading the diabetic foot wound. *Diabetes Care* 24:1019-1022, 2001

¹⁸ Cavanagh PR, Owens TM. Nonsurgical strategies for healing and preventing recurrence of diabetic foot ulcers. *Foot and Ankle clinics N Am* 11:735-743, 2006.

reporting and analysis.

Home and Community Care will be developing its 2018-2019 **Quality Improvement Plan (QIP)** aligning work started and underway with key metrics, with the support of Health Quality Ontario. This plan is an annual requirement.

PART 2: GOALS AND ACTION PLANS

Goal (s)

As articulated within our IHSP, the following are the goals identified for Quality – Positive person experiences and Outcomes across the Care Continuum focused on the delivery of home and community care services:

Ensure the needs and voice of the patient and their family shape how services are delivered

- Support end-of-life experiences that are respectful of the wishes of the patient and family
- Foster a positive patient experience by supporting care continuity and flexible service delivery models
- Provide patients and their families with more control over the services that they need by exploring self-directed care opportunities
- Be inclusive of people's circle of support in the planning and provision of care delivery models

Coordinate and integrate care with the person at the heart of the health care system

- Involve people with the lived experience as active team members on program development or quality improvement committees by utilizing experience based design
- Support people to find the care that fits their needs by fostering a no wrong door culture
- Develop models for positive patient experiences by learning from industries who excel in customer service

Foster a culture of health and community wellness

- Apply a health equity lens for program development and health care service delivery
- Alleviate social isolation for those seniors who live at home and find it hard to get out by exploring innovative partnership models

Government Priorities

- *Patients First: Action Plan for Health Care*, 2015
- *Excellent Care for All Act*, 2010
- 2018-19 Mandate letter: Health and Long Term Care
- *Patients First Act*, 2016
- *Patients First: A Roadmap to Strengthen Home and Community Care*
- *Levels of Care: Patients First: A Roadmap to Strengthen Home and Community Care*

Action Plans/Interventions

Action Plans		
	Expected Status (as of March 31, 2019)	Expected Completion Date
Action Plan 1: The Self-Directed Care initiative will be designed based on further ministry direction.	In progress	March 2019
Action Plan 2: Subject to ministry direction and required adjustments, the Special Needs Strategy initiative will focus on: • Integrated Rehab: a) Development of common tools, processes, intake, referral, waitlist and consent b) Electronic sharing of information c) Transition planning d) Detailed risk analysis • Model of care for children with medical complexity • Service delivery model re-design for specialized dedicated service provider(s) for children's services	Complete Complete Complete	April 1, 2018 March 31, 2019 March 31, 2019
Action Plan 3: Automated Provider Reporting will focus on implementation of the new CHRIS feature for the LHIN and service providers.	In progress	September 2019
Action Plan 4: Home Care Assessment Modernization Project (local deliverables) – InterRAI is expected to be completed with the transition of the LHIN from RAI-HC to InterRAI HC and associated supports	In progress	April 2018 (2 nd phase introduction)
Action Plan 5: Wound Care Best Practices: Develop a regional wound care strategy and implementation of Total Contact Cast for patients with diabetic foot ulcers: a) Expansion of clinic service capacity b) Ongoing program enhancements	In progress	March 2020
Action Plan 6: Risk Event and Complaints Management System Renewal	Complete	March 31, 2019

4) French Language Services

In alignment with the requirements set out in the *French Language Services Act, 1986* (FLSA), the LHIN continues to strengthen relationships with our diverse Francophone communities through local engagements. The LHIN actively engages local Francophone residents through various methods:

- Community consultations and surveys
- Representation on committees, such as our French Language Services (FLS) Community of Practice (CoP)

By working closely with our French Language Health Planning Entity, Reflet Salvéo, we continue to gain a better understanding of Francophone health needs. We thereby implement a French Language Services Joint Action Plan (JAP) to:

- Build FLS capacity of health service providers
- Improve access to health services in French across the LHIN's health sector priorities
- Increase access to primary care French language services at the sub-region level
- Include the Francophone voice at the sub-region level to help facilitate increasing home and community capacity resources for FLS
- Improve Francophone patients' experience

Together we are harmonizing our actions to facilitate Francophone navigation across the health care system. Further, we are planning for Active Offer and the delivery of French language health services, with a view to maximize the Francophone communities' contribution in terms of system improvements, which better address their needs.

The LHIN promotes the Active Offer of FLS through Francophone representation on our Board of Directors, including local conditions in our Service Accountability Agreements with our health service providers, ensuring that:

- Our visual identity, communications and publications intended for the public are available in both official languages where appropriate
- Signs are prominently posted to let patients/clients know that services are available in both official languages

The LHIN Board of Directors and Senior Management Team are informed of and endorse its obligations to FLS. The LHIN commits to applying a Francophone lens when planning and integrating health services in the current health care system transformation process, in order to improve Francophone access to appropriate health services. We continue to support the development of primary care, home and community care, and long-term care initiatives for Francophones, and respond to the needs and challenges identified through community engagement initiatives.

In collaboration with Reflet Salvéo, we continue to work with our FLS identified health service providers to help them build their capacity to implement an Active Offer of FLS and to keep the Francophone community members informed of available FLS through consistent messaging using both the LHIN and Reflet Salvéo websites and social media accounts, and our FLS CoP communications.

The FLS CoP has established a network of strong and innovative partnerships from multidisciplinary and cross-sector organizations to help us advance pathways to culturally and linguistically equitable health care. Through this FLS CoP, health service providers are mutually supported with ideas of promising practices to identify and address the needs and concerns of its Francophone residents. Together we strive to break down linguistic and cultural barriers for this priority official language population.

Through the newly created role of Bilingual Health Promoter at the East Mississauga Community Health Centre, the LHIN will pilot strategies aimed at improving the health and well-being of Francophone community members who face major barriers to accessing linguistically and culturally appropriate health care services, thus enabling them greater control over their health. We will facilitate health promotion services targeting physical, social and mental health well-being and strive to connect communities to relevant and meaningful resources, thereby improving their health literacy. We will develop mechanisms to ensure the integration of FLS in the local health care system, thereby improving access to services in accordance with the FLSCA.

5) Indigenous Peoples

The diverse urban First Nations, Métis and Inuit populations who live in the Mississauga Halton region face significantly poor health outcomes, including shorter life expectancy and a higher prevalence of chronic diseases.

In an effort to establish and implement strategies to build health care system capacity to better serve Indigenous health and social needs, we engaged with local Indigenous leaders, organizations and partners, such as the Ontario Indigenous Cultural Safety (ICS) Program, the Indigenous Diabetes Health Circle, the Peel Aboriginal Network (PAN) and the Métis Nation of Ontario-Credit River Métis Council (MNO-CRMC) in the design of this ABP.

As there is a critical need for increased Indigenous cultural safety within our health care system, health service providers across our region have access to interactive online Indigenous Cultural Safety (ICS) training. Core ICS trainings are designed as foundational courses to increase knowledge, enhance self-awareness and build skills related to working effectively with Indigenous people. Participants are exposed to various terminology and aspects of colonial history such as residential schools, Indian hospitals, Indian agents, and the Sixties Scoop, which lends itself to a better understanding of the legacies of colonialization that continue to contribute to poor health outcomes for Indigenous peoples today.

This invaluable training effectively brings to light service provider biases and legacies of colonization that currently persist and affect service accessibility and health outcomes for Indigenous populations. Additional in-person training opportunities will also be offered to health and social service leaders in the region, such as the “Creating Transformation in Service Settings: Getting to the Roots of Tolerance” workshop. It is our collective hope that through education and ongoing learning opportunities, we will aim to correct health service provider bias, stereotyping and discriminatory attitudes and behaviours that continue to impact Indigenous patients.

Together in partnership with our local Indigenous partners and health service providers, we developed a two-year project that focuses on addressing four priorities: mental health and addiction, chronic disease/diabetes, Indigenous cultural safety and community wellness.

Our joint project will hire Elders, Traditional and Spiritual Healers, and Indigenous Diabetes Wellness Facilitators to provide culturally appropriate services at PAN and MNO-CRMC. By improving access to traditional ceremonies, healing services and community events, we strive to provide increased opportunities for Indigenous communities to come together and participate in culturally safe and enriched spaces. Focusing on holistic Indigenous health and wellness, we strive to improve the healing continuum which includes the physical, mental, emotional, spiritual and cultural aspects of life. In the process of reducing barriers to culturally appropriate health care, Indigenous individuals and families will be empowered to enhance their well-being within an Indigenous framework and meet their physical, spiritual and mental health care goals while also maintaining connections to their cultures.

Together with Indigenous partners, we aim to positively impact Indigenous individuals, families and communities, as well as to equip providers with sustained capacity in awareness, education and culturally appropriate service delivery.

6) Performance Measures

To monitor the success of the 2016-2019 IHSP, three “big dot” performance metrics have been identified for which the data is reliably obtained in a timely, accurate and consistent manner. The metrics were selected based on the Mississauga Halton LHIN’s approach to system-level improvement, across sectors with health service providers. As there are no system-level “big dot” indicators identified to monitor performance of the strategic priority Quality, it is anticipated that the Mississauga Halton LHIN Regional Quality Table will address this gap.

The metrics are:

- **Hospital readmission rates:** helps to monitor access to other community services and programs and assess the efficacy of the inter-relationship of accountability of patient care between providers
- **Avoidable emergency revisits:** focuses on the ability of residents to access more appropriate services

These two metrics are focused on avoidable hospital utilization.

- **Alternate level of care** for both acute and post-acute: monitors care at the right place at the right time for residents, and speaks to capacity to deliver services outside of the acute sector. This metric provides a signal to resourcing shortfalls in the community, long-term care and support within the home.

This metric is focused on access to right place and right care.

The Mississauga Halton LHIN’s **Performance Scorecard System** and the **draft Mississauga Halton LHIN Quality Report** will monitor and manage performance at the health system, sector and individual project level. The Mississauga Halton LHIN Quality Report uses Health Quality Ontario’s six attributes of a high-performing health system and guides the identification of key performance metrics that can be uniquely applied and tailored to measure progress of the 2016-2019 IHSP.

As noted above, the Mississauga Halton LHIN has identified 11 action plans to help improve access and 11 action plans to build capacity including through LHIN delivered services. Each project has performance indicators aligned with at least one of the three metrics identified to monitor the success of the IHSP (see above). All Ministry-LHIN Accountability Agreement indicators will be reported to the Quality Committee of the LHIN Board. In addition, there are LHIN level work plans that identify performance indicators associated with the action plans. These developmental indicators will be monitored at the project level against Mississauga Halton LHIN specific targets.

The Mississauga Halton LHIN’s Patient Complaint process is part of a corporate escalation that includes home care staff, such as the patient ombudsman, to understand and navigate patient complaints in a compassionate, consistent, fact-based process, with solution-based approaches, that are intended to benefit other direct service delivery agencies across the LHIN using a CQI approach. The LHIN recognizes the complexity of legal and legislative structures between

LHIN-delivered services and health service providers, and has consolidated its risk and quality processes to enable best practices across all service delivery agents of the LHIN. A key initiative in this LHIN will be to replace its existing software, and implement an enterprise risk management tool whereby dynamic reporting and analysis will be enabled, to better understand the themes of complaints, root cause analyses and better patient experiences throughout the region. The Quality Committee of the Board has sub-group responsibility of the patient complaints and quality and risk management processes at the LHIN.

7) Risks and Mitigation Plans

The following risks and mitigation plans are generally associated with the 2018-2019 ABP. Risk monitoring in-year will include a monthly risk review as part of the Project Management Council (PMC) process with appropriate adjustments and actions as recommended by PMC for initiatives on the organizational work plan and portfolio-level management for work not monitored by PMC but included in the ABP. The LHIN also has an established process of enterprise risk management and quarterly reporting to the ministry.

Risk/Barrier	Mitigation Plan
The implementation of the ministry's health system transformation requires intensive and strategic change management approaches within and across sectors.	• Prioritize initiatives for regional capacity planning that have the biggest impact on patient experience and improve overall system-level outcomes before implementation • Use staged implementation where possible to address initiative interdependencies • Recalibrate baseline plan to address capacity as required using a resource coordination mechanism, project management and management of initiative interdependencies • Identification of possible integration opportunities by engaging providers early and seeking staff and partner input on how to manage partner relationships, and by engaging with patients and families to assess their needs and implement approaches to address their needs during change • Work with each sector to identify opportunities to increase the skill and confidence of staff to manage change • Create an environment of collaboration and negotiation internally and externally • Work with leaders as 'change agents' • Put appropriate policies in place to support staff working in different environments • Legitimize personal coping strategies (e.g. taking vacation, participation in wellness activities)

Risk/Barrier	Mitigation Plan
Regional capacity planning has an adverse impact on current system-level resources as system changes strategically shift resources from hospital to community and ensure appropriate community investments to enhance capacity.	• Acute care development must also be supported as required to meet population growth needs and infrastructure challenges • Continue to enhance operational and strategic governance structures to support stakeholders in making change to their current processes • Supporting health service providers to examine opportunities for integration and standardization as well as leveraging other resources in the LHIN (i.e. Mississauga Halton LHIN Regional Learning Centre)
Inability to access timely high quality data at regional system and client levels.	• Enhance current information management processes and data quality • Collaborate with partners in the community, not-for-profit as well as experts in data to leverage best practices, skills and resources • Continue to strengthen primary care data quality to inform planning
Lack of knowledge, skill and comfort level with new enabling technologies may contribute to low adoption rates in addition to resistance to modifying existing workflows.	• Ensure technology enablers are prioritized in alignment with support projects on the organizational work plan • Address lack of knowledge, skill and comfort level with new enabling technologies to increase adoption rates and lower resistance to modifying existing workflows • Identify current information technology platforms that can be leveraged and updated to meet needs of new initiatives
The LHIN is emerging from a state of transition following May 31, 2017 when the former Mississauga Halton LHIN and Mississauga Halton CCAC merged into one new organization.	• Significant progress has been made and in 2018-2019 the focus will be on ensuring all transition work is completed or on track for completion • Change management efforts will continue and be enhanced by the opportunity for staff and stakeholders to help shape the new strategic plan
Lack of local health service providers buy in with supporting the development of French language services appropriate to needs, undermines success.	• Identify and collaborate with French language services champions within our identified health service providers or within our partner LHINs to help build capacity and a supportive network

8) LHIN Operations and Staffing Tables

Table A: LHIN Spending Plan

	2017/18 Estimated Actuals	2018/19 Allocation	2019/20 Planned Expenses	2020/21 Planned Expenses
Allocation: Home Care/LHIN Delivered Services¹				
Salaries (Worked hours + Benefit hours cost)	\$29,681,823	\$31,342,102	\$31,342,102	\$31,342,102
Benefit Contributions	\$7,211,995	\$8,143,185	\$8,143,185	\$8,143,185
Med/Surgical Supplies & Drugs	\$6,180,366	\$5,180,366	\$5,180,366	\$5,180,366
Supplies & Sundry Expenses	\$782,940	\$533,288	\$533,288	\$533,288
Equipment Expenses	\$2,683,631	\$2,483,631	\$2,483,631	\$2,483,631
Amortization on Major Equip, Software License & Fees		\$0	\$0	\$0
Contracted Out Expense	\$129,560,762	\$121,902,029	\$121,902,029	\$121,902,029
Buildings & Grounds Expenses		\$0	\$0	\$0
Building Amortization		\$0	\$0	\$0
TOTAL: Home Care/LHIN Delivered Services	\$176,101,517	\$169,584,601	\$169,584,601	\$169,584,601
Allocation: Aggregated Operation of the LHIN²				
Salaries (Worked hours + Benefit hours cost)	\$3,218,076	\$3,646,651	\$3,646,651	\$3,646,651
Benefit Contributions	\$744,487	\$974,095	\$974,095	\$974,095
Med/Surgical Supplies & Drugs		\$0	\$0	\$0
Supplies & Sundry Expenses	\$1,133,628	\$1,166,154	\$1,166,154	\$1,166,154
Equipment Expenses	\$118,366	\$0	\$0	\$0
Amortization on Major Equip, Software License & Fees		\$0	\$0	\$0
Contracted Out Expense		\$0	\$0	\$0
Buildings & Grounds Expenses	\$25,034	\$0	\$0	\$0
Building Amortization		\$0	\$0	\$0
Sub-total: LHIN Operations	\$3,775,591	\$4,925,900	\$4,925,900	\$4,925,900
Sub-total: LHIN Operations Initiatives	\$1,041,000	\$861,000	\$861,000	\$861,000
Sub-total: LHIN Operations Digital Health	\$423,000	TBD	TBD	TBD
TOTAL: Aggregated Operation of the LHIN²	\$5,239,591	\$5,786,900	\$5,786,900	\$5,786,900
Allocation: Integrated LHIN Administration/ Governance³				
Salaries (Worked hours + Benefit hours cost)	\$9,731,519	\$9,941,236	\$9,941,236	\$9,941,236
Benefit Contributions	\$2,436,608	\$2,584,721	\$2,584,721	\$2,584,721
Med/Surgical Supplies & Drugs		\$0	\$0	\$0
Supplies & Sundry Expenses	\$2,124,442	\$2,166,153	\$2,166,153	\$2,166,153
Equipment Expenses	\$742,002	\$742,002	\$742,002	\$742,002
Amortization on Major Equip, Software License & Fees	\$211,613	\$211,613	\$211,613	\$211,613
Contracted Out Expense		\$0	\$0	\$0
Buildings & Grounds Expenses	\$2,817,414	\$2,817,414	\$2,817,414	\$2,817,414
Building Amortization	\$36,861	\$36,861	\$36,861	\$36,861
TOTAL: Integrated LHIN Administration/ Governance	\$18,100,459	\$18,500,000	\$18,500,000	\$18,500,000
TOTAL: LHIN SPENDING PLAN	\$199,441,567	\$193,871,501	\$193,871,501	\$193,871,501

Notes:

- Home Care/LHIN Delivered Services envelope includes direct services as defined in Schedule 7, Table 1 of the 2015-2018 Ministry LHIN Accountability Agreement.
- Aggregated Operation of the LHIN includes:
 - LHIN Operations: LHINs' mandated system operations/activities related to planning, funding and integrating.
 - LHIN Operations Initiatives: Activities that are one-time and/or require separate reporting as per ministry funding letters. (E.g. French Language Services and Aboriginal Engagement).
 - LHIN Operations Digital Health: The coordinated and integrated use of electronic systems, information and communication technologies to facilitate the collection, exchange and management of personal health information in order to improve the quality, access, productivity and sustainability of the healthcare system.
- Integrated LHIN Administration/Governance envelope includes indirect costs such as administration and overhead expenses of the combined organization.

Table B: LHIN Staffing Plan (Full-Time Equivalents or FTE¹)

	2017/18 Actuals as of February 28/2018	2018/19 Forecast	2019/20 Forecast	2020/21 Forecast
Home Care/LHIN Delivered Services²				
Management and Operational Support (MOS) FTE	114.0	114.0	114.0	114.0
Unit Producing Personnel (UPP) FTE	286.3	298.8	298.8	298.8
Nurse Practitioner (NP) FTE	5.1	5.1	5.1	5.1
Physician FTE				
Total Home Care/LHIN Delivered Services FTE	405.4	417.9	417.9	417.9
LHIN Operations³				
MOS FTE	19.0	19.0	19.0	19.0
UPP FTE	20.0	20.0	20.0	20.0
NP FTE				
Physician FTE				
Total LHIN Operations FTE	39.0	39.0	39.0	39.0
LHIN Operations Initiatives⁴				
MOS FTE				
UPP FTE	2.0	1.0	1.0	1.0
NP FTE				
Physician FTE				
Total LHIN Operations Initiatives FTE	2.0	1.0	1.0	1.0
LHIN Operations Digital Health⁵				
MOS FTE	2.0	TBD	TBD	TBD
UPP FTE				
NP FTE				
Physician FTE				
Total LHIN Operations Digital Health FTE	2.0	TBD	TBD	TBD
Integrated LHIN Administration/ Governance⁶				
MOS FTE	50.8	53.8	53.8	53.8
UPP FTE	53.0	53.0	53.0	53.0
NP FTE				
Physician FTE				
Total FTE	103.8	106.8	106.8	106.8
TOTAL FTE SUMMARY	552.2	564.7	564.7	564.7

Notes:

1. One Full Time Equivalent equals 1950 hours per year. One FTE may be comprised of multiple staff.
2. Home Care/LHIN Delivered Services envelope includes direct services as defined in Schedule 7, Table 1 of the 2015-2018 Ministry LHIN Accountability Agreement.
3. LHIN Operations includes LHINs' mandated system operations/activities related to planning, funding and integrating.
4. LHIN Operations includes activities that are one-time and/or require separate reporting as per ministry funding letters. (E.g. French Language Services and Aboriginal Engagement).
5. LHIN Operations Digital Health includes the coordinated and integrated use of electronic systems, information and communication technologies to facilitate the collection, exchange and management of personal health information in order to improve the quality, access, productivity and sustainability of the healthcare system.
6. Integrated LHIN Administration/Governance envelope includes indirect costs such as administration and overhead expenses of the combined organization.

9) Integrated Communications Strategy

Business Objectives

The LHIN 2018-2019 ABP operationalizes the goals contained in the 2016-2019 IHSP *Partnering for a Healthy Community* and is in line with our vision of a seamless health system for our communities, promoting optimal health and delivering high quality care when and where needed. Specifically,

- **Access**
 - Bring Care Closer to Home
 - Integrate and Partner to Improve Access & Services Through Coordinated Efforts
 - Make It Simpler to Navigate the Health Care System and Reduce Barriers to Access
- **Capacity**
 - Quantify Capacity Needs and Expand Supports to Care Providers
 - Enhance Program Capacity to Support the Right Care in the Right Place
 - Recognize and Address the Impact Social Determinants Play in Building a Sustainable, Person-Centred Health Care System
- **Quality**
 - Ensure the Needs and Voice of the Patient and Their Family Shape How Services are Delivered
 - Coordinate and Integrate Care with the Person at the Heart of the Health Care System
 - Foster a Culture of Health and Community Wellness

Communications Objectives

The LHIN's communications objectives are to:

- Foster an understanding and raise awareness of:
 - Health care services in our region and provided by our LHIN for patients and caregivers, which also support health system navigation
 - Ontario's transformation of the health care system
 - Mississauga Halton LHIN's leadership in managing the transformation of the local health system and its expanded role through the *Patients First Act, 2016*.
 - The key initiatives – and their progress – that are helping the LHIN achieve its IHSP priorities
- Educate and build awareness among health service providers about:
 - The shared accountability of the LHIN and health service providers in transforming the health system
 - Their role to identify opportunities and work together to integrate services to provide patient-centred care that is appropriate, coordinated, effective and efficient, based on funding available
 - The IHSP and the importance of aligning its initiatives within their strategic plans, so we are collectively working towards the same goals
- Guide the communications of the LHIN (Board and staff) and health service provider partners involved in initiatives contained in the 2018-2019 ABP to ensure they support objectives, target audiences are reached and messages are clear
- Work in partnership with individuals and groups to enhance the LHIN's communication efforts locally, align and share key messages and build stronger trusted relationships

- Through consistent use of the LHIN visual identity, shape understanding of our organization and what it represents, so it is quickly and easily recognizable
- Build confidence among Ontarians that:
 - Progress is being made to improve access to health services
 - Progress is being made to improve the patient experience
 - The system is sustainable, being effectively managed, providing value for tax dollars
 - The system is transparent

Engage patients, caregivers, providers, employees, and system leaders to become active participants in and ambassadors for transformation.

Context

- In his November 2017 Mandate Letter to the Mississauga Halton LHIN, Minister Hoskins outlines our collective priorities, some of which include: the patient experience, health equity, access to primary care and mental health and addiction services, reducing wait times, reducing the number of people in a hospital bed waiting for the right level of care, supporting seniors, and breaking down silos between health care sectors and providers
- In her September 2016 Mandate Letter to the Minister, the Premier outlined four specific priorities consistent with key objectives from the *Patients First: Action Plan for Health Care*: providing timely access to the right care; delivering coordinated and integrated care in the community and closer to home; providing education, information and transparency to support informed decision making; and making decisions based on value and quality to sustain the health care system for generations to come. These commitments are shared by the LHINs as we work with local system partners to continue to move provincial and local health care priorities forward
- The **2018 Ontario Budget** indicates a need for faster access to health care and providing more coordinated care in the community. In line with this, through the stewardship of over \$1.6 billion of public funds allocated to our health service providers and home and community care, the LHIN is making the system work better for people, creating a more seamless system and strengthening the continuum of care as people move from one part of the health care system to another
- **Patients First: Ontario's Action Plan for Health Care**, the next phase of Ontario's plan for building a health care system that puts patients first, enabling the government to deliver better, easier access to care, depends on LHINs – as key partners – to transform our health care system into one that puts the needs of patients at its centre
- **Patients First: A Roadmap to Strengthen Home and Community Care**, announced by the Minister in May 2015, is a plan to transform home and community care. Together with our health service providers, the LHIN is working to continue to implement the initiatives outlined, providing more access to care in the home and community
- The LHIN has a critical leadership role to play in key provincial initiatives such as:
 - Strengthening home and community care through reduced wait times, and improved coordination and consistency with input from patients and caregivers
 - Expanding access to mental health and addiction services through the development of and investment in programs that better connect people to services that are more accessible, equitable and coordinated
 - Building primary care as the foundation of the health care system, addressing the needs of local populations in sub-regions and improving access and transitions between care

- Improving access to the right care for all Ontarians at every life stage through greater choice for palliative and end-of-life care, expanded caregiver supports, a strategy for dementia, stronger long-term care, and increased linkages between primary care, specialist care and other health care providers
 - Promoting health equity through understanding the impact of social determinants of health on health outcomes, and identifying and addressing health disparities
- The LHIN's 2016-2019 IHSP and the initiatives laid out in this ABP are strategically aligned with government directions and priorities and recognize the joint accountability of the Ministry of Health and Long-Term Care and LHINs to serve the public interest and effectively oversee the use of public funds
- As the local system managers who play a central leadership role in driving health system transformation and putting patients first, we will continue to build on our progress to date and leverage our expertise as we move forward to achieve an integrated health care system in Ontario.

Target Audience

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

- General public
 - Patients, clients, consumers and residents
 - Caregivers/family members
 - Diverse populations including Indigenous, Francophone, immigrant, refugee, ethno cultural and racialized communities
- Health service providers and key stakeholders (LHIN-wide, cross-LHIN and pan-LHIN)
 - Mississauga Halton LHIN health service providers – administrative and governance
 - Primary care providers including physicians and nurse practitioners, and specialists
 - Professional associations such as Ontario Hospital Association (OHA), Ontario Medical Association (OMA), Ontario Home Care Association (OHCA)
 - Public Health
- Board of Directors, employees, advisory groups and committees
- Community organizations, government, administrative leadership and elected officials
 - Municipal
 - Regional
 - Provincial – including MOHLTC and other ministries as appropriate
- Media

Key Messages

Provincial

- Ontario is increasing access to care, reducing wait times and improving the patient experience through its Patients First: Action Plan for Health Care – protecting health care today and into the future
- The Patients First: Action Plan for Health Care sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre by improving the health care experience: increasing access, connecting services, informing patients and protecting our health care system

- By putting patients first in everything we do, we will provide faster access to the care patients need today and make the necessary investments to ensure our health system will be there for patients for generations to come
- Changes underway supported by the *Patients First Act, 2016* have expanded the LHIN mandate and will give LHINs the tools, oversight and accountability they need to better integrate local health care services and coordinate care across the care continuum in a way that better serves patients
 - In May and June 2017, home care services and staff transferred from CCACs to LHINs. This was a structural system change that will help patients and their families get better access to a more local and integrated health care system. The process happened in carefully planned stages and was seamless for patients and home care clients. There was no disruption to care and providers remained the same
- Once fully implemented, these changes will make local health care more responsive to local needs:
 - Patients will benefit from improved access to primary care, including a single number to call when they need health information or advice on where to find a new family doctor or nurse practitioner
 - Primary care providers, inter-professional health care teams, hospitals, public health units and home and community care providers will be better able to communicate and share information, to ensure a smoother patient experience and transitions
 - Administration of the health care system will be streamlined and reduced, with savings put back into improving patient care
 - With Patient and Family Advisory Committees in every LHIN, the voices of patients and families in their own health care planning will be strengthened
 - There will be an increased focus on cultural sensitivity and the delivery of health care services to Indigenous peoples and French speaking people in Ontario

Local

- The Mississauga Halton LHIN is the key organization that brings together local health care partners to develop collaborative solutions leading to coordinated, value-driven models that promote a better patient experience
- The Mississauga Halton LHIN's expanded role in primary care, and delivery of home and community care is supporting improved access and better integrated services for patients
- The Mississauga Halton LHIN has steadily prepared for high growth and high demand by enhancing and integrating programs, building capacity in our communities, and strengthening primary care and supportive care so people stay healthier and out of hospital longer
- By talking and listening to local patients and caregivers, health care providers, community residents and partners, and through careful strategic planning and research, the Mississauga Halton LHIN identifies and funds local initiatives that support a seamless health system for our communities
- Through our seven sub-regions, we continue to plan care that is more localized. Looking at the unique characteristics of our neighbourhoods enables the Mississauga Halton LHIN to better identify and respond to community needs and ensure that patients across the entire LHIN have access to the care they need, when and where they need it. This includes the needs of Indigenous communities, Francophone Ontarians, newcomers and other individuals and groups within the Mississauga Halton LHIN whose health care needs are unique and who often experience challenges accessing and navigating the health care system.

- The Mississauga Halton LHIN is driving innovation by investing in new ideas at a local level, enabling proven solutions to be scaled up across Ontario to achieve larger health system impact
- For the period 2016-2019, the Mississauga Halton LHIN has identified access, capacity and quality as the three strategic priorities to improve residents' health and put patients first
- As the health care system continues to evolve, the Mississauga Halton LHIN remains pivotal in health system transformation and is committed to putting people and patients first by improving the health care experience. We continue to monitor our progress and be flexible in our approach to meet the changing needs of our residents. Working together, we will be successful in *Partnering for a Healthy Community*

Strategic Approach

- Work to support strategic priorities through communication plans and strategies based on specific project objectives and stakeholders
- Build awareness around programs and services that make it simpler to navigate the health care system and reduce barriers to access for patients and caregivers
- Continue to incorporate patients, families and people with lived experience into our health care planning and communication to directly reflect the patient experience and leverage the new Patient and Family Advisory Committee to promote patient engagement
- Provide information on performance and progress, document and successes
- Showcase and communicate specific examples of program accomplishments and how they benefit our region, positioning the LHIN as a valued key player within the transformation of Ontario's health system, and as the lead in health system transformation in the Mississauga Halton LHIN region, while fostering a better understanding of programs and services available to residents
- Develop and leverage opportunities to build our reputation and establish credibility including encouraging third-party experts to publicly express their opinion and share comments on Mississauga Halton LHIN programs and operational achievements
- Support stakeholder understanding of the rationale for change, the transformational model and the plans for implementation
- Engage leaders to champion change throughout the region
- Provide tools that help employees and partners explain the value of the LHIN
- Align health service providers to the shared vision, mission, values and goals of Mississauga Halton LHIN as described in our IHSP and ABP
- Mitigate communication risks derived from negative publicity by proactive planning of risk reduction
- Remain flexible in our communication approach, re-evaluating opportunities to align with structural changes that may arise throughout the year
- Be transparent, accurate and timely when communicating information to all audiences

Tactics – High Level

Communication 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
- Social media
- Annual Report
- Report to the Community
- CEO Report
- Patient information packages, booklets, brochures, etc.
- Media events/announcements
- News releases/launches/local announcements
- Joint communications with health service providers
- Email blasts to stakeholders
- Video (Mississauga Halton LHIN YouTube Channel)
- Face-to-face community engagement
- Stakeholder events
- Newsletters
- Surveys
- Presentations
- Advertising
- Public meetings
- Printed collateral

Evaluation

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

- Feedback from public, patients, employees and key stakeholders through feedback mechanisms to evaluate the effectiveness of communication objectives on awareness, comprehension, attitude and behaviour, and enable shifts where necessary, including surveys, evaluation forms at face-to-face engagement sessions, focus groups, in-person, correspondence, complaints, etc.
- Participation in engagement sessions, events, LHIN-wide committees and through feedback mechanisms
- Effectiveness of HSP engagement including early and frequent understanding of shared accountability in health system transformation and active participation in this transformation
- Volume, accuracy, tone, alignment of key messages and spokesperson quotes in media coverage
- Tracking of social media metrics and website traffic

10) Community Engagement

Community engagement is a core LHIN function in alignment with the *Local Health Systems Integration Act, 2006*.

Engaging the many and diverse communities across the region in the design, delivery and accountability for local health system planning and integration, continues to be a primary goal for the Mississauga Halton LHIN. In order to achieve this goal, the LHIN has established a Patient and Family Advisory Committee to partner with us as we develop a patient and family engagement strategy that will guide us on how best to engage and collaborate with the individuals and communities we serve.

Informed by established health system engagement frameworks developed by Health Quality Ontario (HQO), the Canadian Federation for Healthcare Improvement (CFHI), the International Association for Public Participation (IAP2) and many others, this framework will not only incorporate leading best practices for patient and family engagement, but also reflect the knowledge, insights and history of engagement that already exist within the LHIN, and complement existing forums and efforts of our partners.

While continuing to build upon existing networks and relationships with health service providers and other key stakeholders, the Mississauga Halton LHIN aims to identify opportunities for new partnerships with community-based organizations and increase inter-sectorial collaboration on our engagement with communities. By working together, the LHIN and its partners can expand outreach efforts, learning from each other and building capacity amongst health providers, planners and community members, which will result in more effective and better coordinated engagements with the communities we all serve.