Mississauga Halton **LHIN**

Mississauga Halton
Local Health Integration Network

Annual Business Plan

April 1, 2014 – March 31, 2015

Ontario
Local Health Integration Network

Mississauga Halton
Local Health Integration Network

Annual Business Plan
2014/15

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Mississauga Halton **LHIN**
RLISS de Mississauga Halton

September 12, 2014

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

Dear Ms. Naylor,

On behalf of the Mississauga Halton Local Health Integration Network Board of Directors, it is my pleasure to submit to you our Board-approved Annual Business Plan (ABP) for 2014 – 2015. This plan outlines initiatives planned and underway in the Mississauga Halton LHIN to support achievement of our 2013 – 2016 Integrated Health Service Plan (IHSP).

The ABP for 2014-2015 builds upon the successes achieved in the past year, reflects the current local reality in our LHIN, and takes into consideration results of ongoing community engagement that occurred over the past year with our health service providers and community. The plan further recognizes and supports the health care priorities articulated by the Ministry of Health and Long-Term Care, namely Heathier People, Healthier Communities and a Healthier System for All as articulated in the Action Plan for Health.

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

Yours truly,

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

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

1.1.2 Mandate

The Mississauga Halton Local Health Integration Network (MH LHIN) is one of fourteen LHINs in the Province of Ontario that were established as crown agencies by the Ministry of Health and Long-Term Care. The legislative authority for Local Health Integration Networks (LHINs) is found within the *Local Health System Integration Act, 2006* and identifies that the mandate of a LHIN is to plan, fund and integrate local health care services provided within its boundaries.

To achieve the above noted mandate, the Mississauga Halton LHIN Board of Directors has articulated their mission, vision and values statements to be:

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

Innovation, Integrity
Accountability, Partnership
Respect, A Holistic Approach

The Mississauga Halton LHIN Annual Business Plan for 2014 – 2015 is the sixth annual business plan (ABP) produced by the Mississauga Halton LHIN since its inception in 2006. The 2014 – 2015 ABP identifies the activities that the Mississauga Halton LHIN will undertake in the upcoming fiscal year to achieve the strategic priorities articulated within the LHIN's Integrated Health Services Plan (IHSP) for 2013 – 2016 "*Partnering for a Healthier Tomorrow".* This Annual Business Plan represents the work to be undertaken within year two of the three year strategic planning cycle.

In 2012, the Mississauga Halton LHIN conducted an extensive community engagement exercise with local health service providers, external partner groups, consumers, caregivers and the general public to develop the 2013 – 2016 Integrated Health Services Plan. The plan represents the voices of our community and speaks to the opportunities that people identified, the challenges that they currently face and the need to work with our partners to build our local health care system and collectively better meet the needs of our residents.

The strategic priorities and goals of the IHSP were developed in alignment with both the priorities of the Ministry of Health and Long-Term Care, as articulated within "Ontario's Action Plan for Health Care", and the provincial LHIN System Imperatives.

The Provincial Action Plan for Health Care identifies three key priority areas:

1. Keeping Ontario Healthy
2. Faster Access and a Stronger Link to Family Health Care
3. Right Care, Right Time, Right Place

The provincial LHIN System Imperatives, developed by the 14 Ontario LHINs are:

1. Enhancing Access to Family Health Care
2. Enhancing Coordination and Transitions of Care for Targeted Populations
3. Implementing Evidence – Based Practice to Drive Quality
4. Holding the Gains

The five key strategic priorities identified in the Mississauga Halton LHIN 2013-2016 IHSP, "*Partnering for a Healthier Tomorrow*", with specific goals, are:

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

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

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

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

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

The achievements of the past year provide a platform upon which the 2014-2015 ABP has been built. Feedback from our community engagements, collaborations with our health service providers and partners, updated provincial priority foci and continued assessment of the changing needs of our growing population have also been considered in the development of our local health priorities for the upcoming fiscal year. The focus of the 2014-2015 ABP is to continue to improve the local health care system to meet the needs of our citizens today and into the future, *Partnering Towards a Healthier Tomorrow.* The action plans identified within this Annual Business Plan will support achievement of our priorities.

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

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

Through the current Ministry - LHIN Performance Agreement (MLPA) between the Ministry of Health and Long-Term Care and the Mississauga Halton LHIN, the LHIN is responsible for the stewardship of approximately $1.36 billion to allocate to local health service providers (HSPs) for the delivery of health care services. A total of 76 health service provider organizations receive funding from the Mississauga Halton LHIN through formal service accountability agreements which define the services to be provided and outcomes to be achieved. Within the Mississauga Halton LHIN there are two public hospital corporations (which includes six sites), 28

long-term care homes (with approximately 4,180 long stay beds), 34 community support service agencies, 10[1] mental health and addiction service providers and one community care access centre (CCAC).

Mississauga Halton LHIN Health Service Provider Allocations – March 31, 2014

Health Service Organizations	# of Agencies	Total Funding (Base + One Time)	% of Total Funding
Hospitals	2 Corporations 6 sites	918,430,770	66.9%
Long-Term Care Homes (LTCH)	28	192,474,886	14.0%
Community Care Access Centre (CCAC)	1	147,342,163	10.7%
Community Support Services (CSS)*	34	79,177,517	5.8%
Mental Health and Addictions	11	35,759,287	2.6%
Investments (unallocated as of March 31, 2014)	-	0	0.0%
TOTAL	76	1,373,184,623	100%

**includes Assisted Living in Supportive Housing and Acquired Brain Injury*

Source: MLPA, Schedule 3 – March 31, 2014

EDITORIAL NOTE: This chart reflects the number of agencies as of March 31, 2014. Effective April 1, 2014 the number of mental health and addictions agencies changes to 10.

In 2013-2014, the Mississauga Halton LHIN embarked upon a new journey, guided by the priorities and goals as set out in its new Integrated Health Service Plan, "*Partnering for a Healthier Tomorrow*". Activities identified within the 2013-2014 Annual Business Plan laid the ground work and foundation for the following two years to

[1] *Effective April 1, 2014 there will be 10 Mental Health and Addictions agencies within the LHIN as a result of the integration of Grace House and Support & Housing Halton*

progress towards achievement of the identified priorities and goals within the IHSP. Working in partnership and collaboration with health service providers, the Mississauga Halton LHIN experienced a number of advancements and successes over the past year. Several action plans initiated last year will continue into the upcoming year to further progress, while some activities related to our IHSP will be initiated this year.

Key work plan activities from the past year and continuing into 2014 – 2015 will support the following initiatives:

- Health Links – continuing to work with our identified lead organizations and partner agencies to develop the local model for enhanced service coordination with primary care to support "high users" of health resources and individuals with complex care needs. Through the increased coordination of services, Mississauga Halton Health Links support a person-centred approach so people will receive the right care, in the right place, when they need it and inappropriate use of valuable health care resources will be reduced.

- Health System Funding Reform (HSFR) and Implementation of Quality Based Procedures (QBPs) – working with our HSFR Local Partnership Committee, we continue to develop a LHIN wide approach to prioritize the implementation of QBPs and initiation of procedure-based funding methodologies. Developing a regional approach to implementation will build a local health care system that delivers high quality service and is sustainable over time.

- Community Capacity Study to Advance the Provincial Seniors Strategy –The Collaborative Community Capacity Study is a joint initiative across the Mississauga Halton and Central West LHINs, CCACs, Community Support Service agencies, Community Health Centres, hospitals and other key stakeholders. The study was initiated in 2013-2014 to provide the LHINs with a better understanding of the capacity of existing resources and options to meet the demand for services in the context of an integrated system of care delivery. As the study findings will be provided in the Spring of 2014, the focus for the upcoming fiscal year is to develop a capacity plan that projects the future community needs for the Mississauga Halton LHIN (over the next 5 years with projections into the 10 and 15 year planning horizon), with a particular focus on seniors. As the study findings should help to identify appropriate models of care delivery, including service types, staff resources (specialties) and innovative approaches to increase programs to support residents to live in the community longer, the LHIN aims to use these findings to support the appropriate amount and mix of community services to support seniors to age at home and ensure caregivers are well equipped to support their loved ones.

- Leveraging Technology for Improved Access to Health Care Services – Building upon the development of central service intake models for access to mental health and addiction services, palliative early identification and diabetes services, opportunities are being explored to leverage existing technological platforms to gain further improvements. The continued use of telemedicine technology within the strategic implementation framework and continued work to integrate and improve access to electronic health care reports for health care professionals will support this key area.

- Health Equity and Continuing Community Engagement - in order to achieve a health care system that supports increased health for our community, we must ensure that people are able to receive services to meet their needs irrespective of their cultural, linguistic, education, sexual orientation or income status. We must also ensure that an understanding of health equity is built within the program and service delivery model of our health service providers. Working with our health service partners we will continue to increase understanding and sensitivity to the diverse needs of our community. We will build upon our relationships with our Francophone and Aboriginal communities and continue to enhance service access opportunities. The revision of our community engagement strategies over the next year will ensure that we continue to reach out to our public and ensure that their voices are heard and included in our planning processes.

- Engagement with Primary Care – To increase the coordination of services, knowledge of our health care professionals of the local health care system and communication between providers, it is essential that we engage with our primary care physicians and better integrate them into our health sytem. Moving through the spectrum of engagement from informing to collaborating (and empowering), the opportunity for physicians to be actively involved in the development of our local health system services and identify what they believe is important to assist them to meet the needs of their patients is essential.

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

Population Growth and Diversity in the Mississauga Halton LHIN

The population of Mississauga Halton grew by 12 percent during the period of 2006 - 2011. By 2015 it is expected that our population will increase by an additional 10 percent. This is the highest population growth rate across the province. The greatest percentage of population growth has occurred in the Town of Milton, which is recognized as the fastest growing community in Canada.

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

We must also recognize that our communities are some of the most diverse in the province. Working in partnership with our funded and external health care partners in the community, we must ensure that services are advertised and provided in ways that reach out to meet the needs of diverse and marginalized groups. Partnerships with Public Health, Regional, City, Community agencies, Education, Business and other key

stakeholders supporting our residents will allow us to build upon existing strategies to ensure that all people are aware of how they can access the health care system without prejudice or fear.

Capacity of Health Care Services to Meet Increasing Demand

As the population continues to grow within the Mississauga Halton LHIN each year, one of the risks we face is the capacity of our health care system to meet the growing demands for service. The Community Capacity Study will provide a framework to guide future decision making and resource allocation within the Mississauga Halton LHIN, and support our plans to ensure that our health service providers are able to meet the increasing demands placed on them by the growing, aging population. In addition, we will be supporting the utilization of quality improvement strategies to improve efficiencies and ensure the best outcomes with our health care resources.

Availability of Long-Term Care Home Services

The Mississauga Halton LHIN has the lowest distribution of long-term care home beds per 100,000 people over the age of 75 years. This shortage of long-term care home services has required that our community based service providers explore opportunities to develop and provide unique services to support people with higher levels of need in their own homes. This also means that those individuals who are placed in long-term care homes often have increased level of care needs and often present with more complex needs. To be able to meet this changing resident profile our long-term care homes must also respond to provide their staff with the knowledge and supports required. Opportunities to increase knowledge exchange opportunities for existing staff will enhance the capacity of organizations to meet the changing needs of their residents.

Health Human Resources

One of the enablers in the transformation of the health care system is the availability of adequate and skilled health human resources in the Mississauga Halton region. The LHIN will need to ensure that its people have access to the right number and mix of qualified health care providers, now and in the future to maintain and sustain high quality person-centred services. This does not only represent the recruitment of new health care providers but also the continued support for and provision of training and knowledge exchange opportunities that supports increased capacity building of our existing workforce.

2.0 INTEGRATED HEALTH SERVICE PLAN 2013-2016 PRIORITIES

2.1 Accessible and Sustainable Health Care

IHSP Priority Description

People want access to a health care system that meets their health care needs now and in the future. To deliver on this priority, over the past year the Mississauga Halton LHIN has been working with health service providers and partners to ensure services are accessible and responsive to the growing needs of our community. Leading practices from across the province and other jurisdictions are reviewed to support the delivery of high quality health care services at the regional level. Programs are developed, implemented and evaluated to ensure the desired outcomes are achieved in the most efficient, fiscally responsible manner,

Knowing what health care services are available, and where and how to access these services is also important. Timely information and support to navigate our health care system is critical to health service providers and consumers, as people experience changing health care needs and the health system continues to evolve. To assist with system navigation, our health care providers must be aware of other services available within our community and share this information with their consumers and families. With changing needs and as people continue their journey there is also need for active support to link people to other services and ensure there is clear communication and collaboration between service providers. Work to increase the opportunity for service providers to share client information, actively support service transitions of care and the development of integrated regional services and strategies will assist us to meet this goal.

To ensure our health care services are available both now and into the future, there must be a focus on ensuring we receive the best value for our health care dollar. To provide a sustainable health care system the LHIN continues to work with our health service providers to explore opportunities to reduce duplication, increase service quality to support system flow and leverage existing high performing system resources. To support the attainment of a sustainable system, work will continue to locally implement Provincial Health System Funding Reform (HSFR) initiatives.

Current Status

In the past year progress has been made in a number of areas to improve the ability of people to access health care services, navigate the system, and ensure that our regional health care system is sustainable to meet future care demands. Achievements aimed to meet this priority area and goals included:

- A conceptual framework for enhanced access to mental health and addiction services was developed. The System Access Model (SAM) provides a centralized regional mental health and addictions service access system to facilitate timely access for people to the services they need, support transitions to additional or changing services and assist with information sharing between health service providers. Recommendations for the leveraging of existing information technology (IT) structures to support this and other central intake functions will be received by end of fiscal year.

- In November 2013, the Mississauga Halton LHIN announced the investment of $1.4 M in the Mental Health and Addictions sector and launched the Opioid Outreach and Treatment Services with our community partners to enhance the treatment system and provide outreach in the region.

- The Regional Hospice Palliative Care Steering Committee progressed in the development of a regional Mississauga Halton LHIN Model of Hospice Palliative Care, which is based on consumers' and families' needs. Based on this model, work was completed to apply the model to each care setting and population as well as criteria (i.e. complexity) and process for referral to the secondary level of care providers (Palliative Care physicians, Palliative Care Advanced Palliative Nurses/Nurse Practitioners, Palliative Pain and Symptom Management Consultants). The three hospice providers are collaborating on the development and piloting (in one site) of a Spiritual /Bereavement service delivery regional model. The Steering Committee has also received permission to customize the UK Gold Standards Framework Prognostic Indicator Guidance tool to use as a tool for early identification of patients. The LHIN led a project for palliative care in Long-Term Care Home (LTCH) settings in collaboration with Lakehead University. Nineteen of the LHIN's twenty-eight LTCHs participated in webinars and PSW training. The Steering Committee has also developed a framework for performance and quality with recommended outcomes, process and balancing indicators for early regional priorities, including; early identification (accessibility) and establishment of region-wide performance measures (efficiency).

- The Mississauga Halton LHIN continues its work to develop a Regional program strategy for Rehabilitative Care. The work includes an analysis of the current model of delivery of publically-funded rehabilitative programs and services in the Mississauga Halton LHIN including inpatient, hospital-based outpatient and publicly funded community-based rehabilitation services. The goal is to develop recommendations for a regional rehabilitation service system model. This model will incorporate stakeholder feedback as well as align with best practices identified through the Provincial Rehabilitative Care Alliance work to enhance patient access to and flow through the system, improve patient experience and outcomes, and improve system integration. The recommendations will be developed to support implementation of the re-designed model of rehabilitative care within the Mississauga Halton LHIN. A Regional Rehabilitative Care Steering Committee was created to develop the integrated regional strategy for access to and the delivery of rehabilitative care services.

- Building on the LHIN's previous Aging at Home investments, community engagement, an environmental scan and provincial alignment with Dr. Sinha's "Living Longer, Living Well" report a framework for a comprehensive, collaborative approach to advancing a seniors strategy has been under development. Designed to be inclusive, innovative and evidence-informed, the framework focuses on the importance of a seamless continuum of care for all seniors in the Mississauga Halton LHIN. Implementation of the Mississauga Halton LHIN Seniors Strategy will be a key focus this year.

- Work to develop a regional telemedicine strategy across the Mississauga Halton LHIN was completed in the past year. The Mississauga Halton LHIN Telemedicine Advisory Committee identified opportunities for the use of telemedicine technology to support joint discharge planning and service transitions as well as tele-mental health nurses for clinical support to patients in North Halton.

- A pilot for a new integrated hospital transition management project model is under initial discussions around implementation. The collaboration between the Mississauga Halton CCAC and Trillium Health Partners was initiated at the Mississauga Hospital site. Results of the pilot project will inform the implementation of the model at a regional level. Further work will continue over the next year.

- The 2013 Holiday Surge Plan worked to prepare people for the winter holiday season and ensure they were aware of the health care options available for them to access during the holiday season should they need access to health care through our annual Feel Better Faster holiday campaign. The Mississauga Halton LHIN worked with health system providers and partners to create a state of health system readiness for surge situations by increasing engagement among partners, improving communications with consumers, and encouraging inter-organizational cooperation (including primary care) to support people to access the right care closer to home, and avoiding the emergency department if not required. In partnership with primary care and the Ministry of Health and Long-Term Care, the LHIN piloted an initiative to increase access to primary care services over the holiday period in Halton Hills.

- With the introduction of the Provincial Life or Limb Policy, regional work was implemented to ensure coordinated access to services for the care of the most critically ill patients. The Mississauga Halton LHIN engaged with the Critical Care and Emergency Department LHIN Leads to review, discuss and strategize on the implementation of the Life or Limb Policy inclusive of repatriation in our LHIN. A work plan was developed and a collaborative methodology for identified stakeholder engagement was established.

- The LHIN worked with its Emergency Department Leaders and partners to use ER P4R funding to implement action plans to improve ER LOS performance

- The Mississauga Halton LHIN worked with its hospitals to continue to progress capital developments. Over the past year, Halton Healthcare Services received approval on the Milton District Hospital Redevelopment project Functional Program, and has moved along the capital planning cycle to stage 3 block schematics, project specific output specifications and request for proposal evaluation criteria. Trillium Health Partners has been aggressively moving along with its clinical services review as a merged entity and has developed its Master Program. The LHIN continues to work actively with its hospitals, health service providers and the Ministry of Health and Long-Term Care to support planning for access to capital requirements in the short and long term.

- Navigation of the health care system has been identified as a key priority area for consumers, health care providers and partners. Over the past year, the LHIN has been working with the Mississauga Halton LHIN CCAC to support the development of the Mississauga Halton Health Line, an on-line and telephone tool that can assist people to know what services are available at the local level. Collaboration with other key stakeholders and partners will continue over the upcoming year to support further development of a navigation tool that meets the needs of the community and its health care providers.

- Work to support the local implementation of Health System Funding Reform progressed with the development of a comprehensive Integrated Orthopedic Capacity Plan (IOCP). The identification of five key system changes for

improved outcomes for orthopedic patients and the creation of working groups to implement and monitor the effectiveness of changes is well underway. One of the working groups has been focused on redesigning the delivery of ambulatory rehabilitation for consumers with Total Hip/Total Knee Replacement to ensure quality of care, standardization of care paths, and maximization of resources based on best practice and consumer need to ensure equitable access to services.

Goals

As articulated within our Integrated Health Service Plan, the following are the goals identified for Accessible and Sustainable Health Care**:**

- Improve access to services to improve consumer flow, quality and safety
    - Establish new ways of working in and with Emergency Departments to reduce wait times
    - Develop innovative and collaborative approaches to reduce unnecessary hospital stays and avoidable hospital admissions and readmissions
    - Leverage evidence-based practices to reduce wait times for priority surgical services (i.e. hips, knees, cataracts, cancer, cardiac bypass)
    - Integrate services to support regional programs and system effectiveness

- Support consumers, families and health care professionals to navigate the health care system
    - Begin planning for transitions early and include all care providers, including informal caregivers and family health care
    - Enhance provider awareness and knowledge of the health care system and available resources
    - Provide service navigation to consumers and their caregivers during transitions within the health care system

- Improve sustainability of the health care system
    - Develop regional, integrated capacity plans to support health system funding reform (e.g. integrated orthopedic capacity plan) and implement funding for selected health programs (quality based procedures)
    - Focus on seniors and those individuals who utilize a significant proportion of our health care resources and how to meet their needs with greater efficiency
    - Work in partnership with health care providers and partners to explore maximizing scope of practice, utilizing services in different ways to improve access
    - Manage growth in capacity required as a result of population increases and aging

The Mississauga Halton LHIN's strategic priority of Accessible and Sustainable Health Care, 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:

- Ontario's Action Plan for Health Care
- ED/ALC Strategy
- Seniors Strategy for Ontario- *Living Longer, Living Well*
- Health Links
- Community Care Information Management (CCIM)
- Mental Health & Addictions 10 year Strategic Plan
- *Excellent Care for All Act*
- Advancing High Quality, High Value Hospice Palliative Care Recommendations
- Health System Funding Reform
- Provincial Life or Limb Policy
- Provincial Rehabilitative Care Alliance
- Assess and Restore Policy

Action Plans	2014/15		2015/16		2016/17	
	Status	%	Status	%	Status	%
1. Enhance access to Mental Health and Addictions services (System Access Model - SAM)	In progress	30	In progress	40	Complete	30
2. Enhance Opioid Outreach Treatment Services	In progress	60	Complete	40		
3. Implement the No Wrong Door Policy - Toward an "Every Door is the Right Door" Service System	In progress	20	Complete	20		
4. Implement regional plans for Hospice Palliative Care in the Mississauga Halton LHIN	In progress	30	Complete	40		
5. Develop and implement a regional rehabilitative care strategy in alignment with directions of the provincial Rehabilitative Care Alliance	In progress	30	In progress	50	Complete	20
6. Develop and implement surge strategy protocols for the holiday season and beyond	In progress	50	In progress	50	Ongoing	

Action Plans	2014/15		2015/16		2016/17	
	Status	%	Status	%	Status	%
7. Plan and implement the Seamless Transition Project	In progress	30	Complete	40		
8. Support the development of appropriate capital plans to meet the future acute and long-term needs of the community	In progress	25	In progress	25	In progress	25
9. Implement a Mississauga Halton LHIN Seniors' Strategy	In progress	30	In progress	50	Complete	20
10. Develop and implement a cross sector working group to enable the development of health services for people with Developmental Disabilities in the Mississauga Halton LHIN.	In progress	40	In progress	40	Complete	20
11. Develop and implement a Mississauga Halton LHIN Telemedicine Strategy	In progress	30	In progress	50	Complete	20
12. Develop a robust health care information source that serves as a navigation tool for health service providers and consumers	In progress	25	In progress	50	Complete	25
13. Plan, develop and implement the Provincial Life or Limb Policy within the Mississauga Halton LHIN	In progress	25	Complete	75		
14. Plan and implement Quality Based Procedures as part of Health System Funding Reform (including the identified 5 key system changes aligned with the MH LHIN Integrated Orthopedic Capacity Plan).	In progress	30	Complete	40		
15. Plan, organize and collaboratively develop a Pan Am ParaPan Am Games 2015 communication and response strategy	In progress	25	Complete	75		

16. Develop a LHIN Emergency Response Plan	In progress	25	In progress	40	Complete	35
17. Develop and implement a Mississauga Halton LHIN Performance Scorecard System	In progress	75	Complete	25		
18. Support the development of community based speciality clinics	In progress	30	In progress	30	Complete	40
19. Develop a Vision (Care) Strategy for the LHIN	In progress	75	In progress	25		
20. Explore opportunities to expand the community health centre model to meet the diverse needs of our community	In progress	30	In progress	30	In progress	30

Measures of Success

Indicators of success for the Mississauga Halton LHIN will be captured through our MLPA Dashboard (Appendix A) and achievement of the 2014-2015 targets as agreed upon by the Ministry of Health and Long-Term Care and the LHIN. The following developmental/monitoring indicators will also be used to help guide planning and program implementation/evaluation:

1. Enhanced Access to Mental Health and Addiction Services
2. Number of formal partnerships with non-funded partners for Opioid Outreach Treatment Services
3. 80% of Community Mental Health and Addiction Health Service Providers have implemented the No Wrong Door Protocols within their organization by Q4 2014/15
4. Develop appropriate data collection tools and measures to track improvements re: access to MH&A services. – Connex Ontario has wait time data
5. Reduction in the number (rate) of hospital days attributed to palliative care
6. Development and implementation of a robust regional Rehabilitative Care strategy including standard definitions and eligibility criteria for regional rehabilitative care services; development and implementation of model for coordinated access to regional rehabilitative care services; development of future supply and demand analysis with recommendations for service realignment/development across continuum of hospital to community based services

7. Reduction in the ED Visit rate for less urgent cases during known ED surge periods; increased (uptake) using the Feel Better Faster website; increased number of Primary Care services available and increased hours of service during holiday periods
8. Reduction in number of patient readmissions post discharge; reduction in wait time to first CCAC/community support service contact following discharge; reduction in administrative time for service referrals; improved and more timely communication flow between providers and with patient/family
9. Reliable projections for clinical service supply and demand for the next 10, 15 and 20 years; gap analysis of current capital infrastructure and projected requirements
10. Development of a MH LHIN Seniors Strategy that is aligned with the Seniors Strategy for Ontario – "Living Longer, Living Well" by leveraging the work of the Aging at Home Strategy. This should help reduce ED wait times and visits, increase the number of people understanding service options and service access, reduce hospital readmissions, increase service provision for regional programs, increase prevention and wellness partnerships that will result in increased knowledge of and participation in healthy programming and increase the quality of life for the frail elderly population
11. Increase in total telemedicine across the Mississauga Halton LHIN by 25%
12. Increase utilization of Mississauga Halton Health Line by 25%
13. Track implementation of life & limb policy action plans of each hospital by specified timelines; track stats provided through CCO on progress and any problem areas; bring areas to attention of working group for resolution
14. Selection of appropriate QBPs (CHF, others) for implementation based upon identified regional needs; development of regional, standardized care pathways; increased number of sites using standardized care pathways. Application of QBP assessment methodology (NEWLY Developed) to determine where work group resources need to be deployed
15. Effective implementation of the Pan Am ParaPan Am strategy in July 2015
16. Development and dissemination of the Mississauga Halton LHIN Business Continuity Plan
17. Emergency Planning training for LHIN staff regarding new role and responsibilities
18. Timely identification of potential performance issues within and amongst the health sectors in the Mississauga Halton LHIN as it relates to the service accountability agreements and aligns with the Integrated Health Service Plan. Trend Analysis; Care Continuum System Impact; Interrelated effect of one area's system performance on another; Impact of investments/Return on Investment and comparator analysis among peers, other LHINs, Ontario
19. Performance Scorecard work book dissemination to key stakeholders monthly/quarterly
20. Number of new community based clinics developed; number of procedures completed within clinic setting
21. Development of a comprehensive vision (care) strategy

Risks / Barriers to Successful Implementation

- Transformational change within all sectors will encounter change management challenges
- Access to Information Technology/Information Management Systems that are integrated across sectors and allow for the secure, timely and useful transfer of information between health service providers
- Timely access to service utilization data at regional system and client levels
- Patient preference for hospital based emergency and urgent care services and resistance to seek non-emergency services elsewhere
- Expression of willingness/preference to “die at home”, but fear enables the seeking of hospital based services for those who are non-acute
- Influence of confounding variables on measurement of project or strategy outcomes
- Client/family perceptions that only hospital based services can meet their needs
- Community Capacity; capital and human health resources
- Project dependencies on provincial work and best practice recommendations from various ongoing initiatives (with regard to Rehabilitative Care)
- Development of supply of services within Specialist MD audience i.e. Psychiatry (telemedicine)

Mitigation Strategies

- Communication materials delivered to the general public on options for non-urgent health care available in appropriate formats and languages for our LHIN population; Use of social media to deliver messages to the public
- Future strategies in care plan development and the provision of clear information to clients/patients and their families concerning “what to expect” with palliative care
- Strategy to access regional cross-sectorial databases
- Involvement of local health service providers and their decision support units to provide timely and quality data into regional databases
- Development of balancing indicators
- Promotion of community based services and their successes
- Develop common value statements to foster acceptance of change strategies
- Stakeholder engagement
- Collaborative Community Capacity Plan
- Central Intake Information Technology/Information Management Workplan established to build IT/IM solution business case
- Working proactively with Specialists to identify and plan strategies to address potential supply issues and increase their participation

Key Enablers for Success

- Stakeholder engagement strategies
- Clearly defined roles for LHIN and stakeholders within project charters
- Timely access to data to support evidence based practice
- Clearly articulated, supported and progressive palliative care implementation
- Identify early adopter agencies to act as system change champions
- Utilize Ontario's Change Model for Health System Transformation to achieve successful, sustainable change
- Advancement of e-health strategies for secure information management and sharing
- Service provider knowledge
- Education and knowledge transfer
- Engagement and increased involvement of Primary care
- Standardized clinical care pathways
- Enhanced and expanded community support programs
- Executive Leadership support from all service provider agencies critical to support the system transformation required to implement the new Rehabilitative Care service model
- Provincial best practice Rehabilitative Care recommendations to enhance impetus for change
- Information Technology/Information Management solutions that ensure the secure, timely and useful cross sector information and notification transfers

2.2 Family Health Care When You Need It

IHSP Priority Description

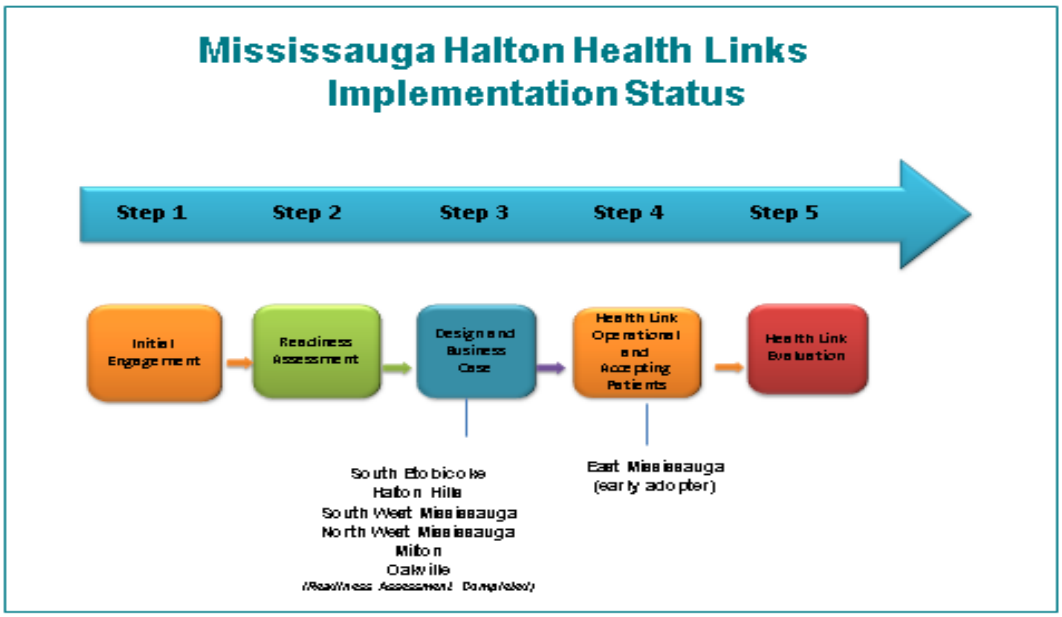
Access to family health care is crucial to the early identification and treatment of health care concerns. Without timely access to a family doctor people may inappropriately access more intensive health care services in our system when they may not be necessary, or may experience increased severity of their condition by not having it treated in a timely manner.

The linkage and integration of family health care to the broader health care system is critical so that people receive the services they need. This may include access to specialist services or information and access to services in the community to assist with better managing health; supporting people to remain living in their homes as long as possible. Through increased collaboration and integration of family health with other community based health care services, a coordinated care model is supported. The development of Health Links within the Mississauga Halton LHIN is aimed at the coordination of care, beginning with access to family health care for those people with complex care needs who are frequent users of the health care system.

Current Status

Over the past year our engagement with primary care has resulted in a number of achievements that have advanced improvements in access to family health care services and the coordination of these services with other components of the broader health care system. Achievements include:

- In 2013 / 2014 seven Health Links were established within the Mississauga Halton LHIN. The East Mississauga Health Link was identified as an early adopter and the remaining six Health Links are in varying stages along the planning continuum:



- Through planning for Health Links, the LHIN conducted significant engagement with primary care physicians and (as well as health service providers, community and key stakeholders) to gauge their interest in and commitment to participating in the Health Links in their area. Through these activities primary care co-leads were identified in six of seven Health Links. Engagement activities also highlighted areas for improvement related to coordination of care which will provide a basis for initiatives to occur in the coming year.

- To collaborate on common issues that affect all Health Links, a forum consisting of LHIN and senior representatives from all seven Health Links has been formed. This forum will promote alignment and knowledge transfer as Health Links progress in their development towards full implementation.

- Our continuing work with primary care physicians, led by our Primary Care Lead, has resulted in the conceptual development of the Mississauga Halton Primary Care Network. The goal of the network is to establish a primary care forum for discussion of both opportunities and challenges associated with the provision of coordinated care to support patients.

Goals

As articulated within our Integrated Health Service Plan, the following are the goals identified for Family Health Care When You Need It:

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

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

The Mississauga Halton LHIN's strategic priority of Family Health Care When You Need It, 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:

- Ontario's Action Plan for Health Care
- ED/ALC Strategy and Wait Times
- Health Links
- Health Care Connect
- Ontario Telemedicine Network
- *Excellent Care for All Act*

Action Plans	2014/15		2015/16		2016/17	
	Status	%	Status	%	Status	%
1. Develop and implement a primary care integration strategy	In progress	40	In progress	40	Complete	20
2. Establish Health Links across the Mississauga Halton LHIN	Complete	100				
3. Improve transitions by leveraging the development of electronic hospital and emergency discharge to support information flow between hospitals and primary care	Complete	50				
4. Evaluate Rapid Response Nurses (RRN) initiative in MH LHIN	Complete	30				
5. Implement pre-printed order sets (PPOS) within LTCHs	Complete	100				

Measures of Success

Indicators of success for the Mississauga Halton LHIN will be captured through our MLPA Dashboard (Appendix A) and achievement of the 2014-2015 targets as agreed upon by the Ministry of Health and Long-Term Care and the LHIN. The Ministry Health Links Performance Measures (Appendix B), once fully defined, will also be used as measures of success.

The following developmental/monitoring indicators will also be used to help guide planning and program implementation/evaluation:

1. Number of physicians engaged in the Mississauga Halton Primary Care Network
2. The percentage of physicians using an electronic medical record system
3. Number of Health Links established; number of patients with complex needs (high users) within the LHIN supported by a Health Link; number of coordinated care plans developed for patients with complex care needs; measurement of patient experience with coordinated care
4. Percentage of hospital patients seen by a primary care physician within 7 days of discharge; percentage of the population served who received a home visit within 48 hours of discharge from hospital from a RRN
5. Enhanced care connections across sectors (hospital, primary care, CCAC and community providers) and patient experience, reduced hospitals readmissions
6. Increase the number of long-term care homes who have implemented Pre-printed order sets

Risks/Barriers to Successful Implementation

- Preconceived stereotypes of patient groups
- Availability of timely, reliable data for evaluation
- Willingness of primary care physicians and specialists to participate in engagement and education sessions
- Lack of standard definitions for high need, high cost/complex health care users

Mitigation Strategies

- Engagement with primary care at early stages of Health Link development to support action plan development
- Create a joint vision for project outcomes
- Engage the Diabetes Clinical Lead to support physician and Endocrinologist participation
- Identification of champions for primary care involvement
- Validate high/complex user definition through retrospective data analysis

Key Enablers for Success
• Community engagement sessions • Communication strategies • Health Service Provider champions for change • Existing networks, partnerships and collaboratives • Education on patient engagement strategies • Information technology management and electronic health records

2.3 Enhanced Community Capacity

IHSP Priority Description

The Mississauga Halton LHIN is home to a rapidly growing seniors population. Consumers and caregivers have articulated that care needs to be provided in a timely and convenient manner – minimizing the need to go to multiple locations for services. Providing the right care, in the right place, at the right time requires the LHIN to work closely with its health service providers, consumers and community stakeholders to ensure we are supporting people where they need care – closer to home.

The enhancement of the capacity of community based services to support people to remain in their homes as long as possible has been a long standing goal of the Mississauga Halton LHIN. With a continued shift in our approach to health care delivery from acute or long-term institutional care to the home, the need to ensure appropriate capacity within the community is paramount. Building capacity refers to adequately managing the volume of services available (and ability to meet growing demands), as well as ensuring providers and caregivers have the skills and supports they require to best meet the needs of an increasingly complex consumer. By providing people the appropriate level of care in the community, the use of more resource intensive levels of care, such as long-term care homes, will be reserved for those people who truly need that level of service.

Current Status

In 2013/ 2014, a number of activities were undertaken to achieve the enhancement of the capacity of our community based services. Key achievements include:

- The Advancement of Community Practice and a Regional Learning Centre was established and identified its priority areas of focus. The six focus areas include; Education and Development, Behaviours, Falls and Exercise, Caregiver ReCharge Program, Medication Management and Incontinence. Work will continue in the upcoming year to support the development of the Regional Learning Centre's priorities, ongoing Community Health Assessment (C.H.A.) competency and meeting greater care competency needs in the community.

- Implementation of the Caregiver Re-Charge program provided additional respite supports for caregivers over the past year. Expansion of the program with the addition of further respite services and Respite Advisors will occur in 2014/15. Program expansion will enable diversity of services in the caregiver Recharge Program in order to address the different care options required by caregivers (e.g. short-stay respite, in home respite adult day, emergency respite, counseling support for care givers)

- A pilot Diabetes MedsCheck program was developed and implemented to standardize the approach to recommending and accessing the Provincial MedsCheck system. This approach ensures that the Diabetes Education Program as well as pharmacy and primary care receive the results of the MedsCheck meeting with the client. Upon evaluation of the pilot, the LHIN will look at adoption of the process to other Diabetes Education Programs in Mississauga Halton.

- An Insulin Initiation Pilot Program was initiated in 2013-14. The program focuses on the delivery of an education program for community pharmacists to increase capacity to support people with diabetes requiring urgent insulin initiation from the hospital, emergency department and/or Endocrinologists' offices. Care would be provided after hours, weekends and/or as a first contact prior to attending a Diabetes Education Program (DEP). As part of the program, Pharmacists will actively partner with the DEPs and refer the patients back to the DEPs as part of the circle of care. The program will be evaluated and expanded if the outcomes are successful.

- The MH LHIN successfully developed and implemented the expansion of Physiotherapy services within the community as part of the provincial reform of Physiotherapy Services. Expansion of services included 54 community locations providing 142 exercise classes and 135 falls prevention classes for seniors supporting 5,790 people. As a result of LHIN and Ministry collaborative planning, an additional 7 community based physiotherapy clinics were established within the LHIN. In total, there are 11 provincially funded clinics that support the delivery of physiotherapy services across our community.

- The initiation of a community capacity study in collaboration with the Central West LHIN. Supporting the provincial Seniors Strategy, the study will project the future community needs over the next five, ten and fifteen years. The plan will identify appropriate models of care delivery, including service types, staff resources (specialties) and innovative approaches to increase programs to support residents to live in the community longer. The overarching goal is to identify the appropriate amount and mix of community services to support seniors to age at home, and ensure caregivers are well equipped to support their loved ones. The results of the study (which will be completed in October 2014) will help guide our planning for the upcoming year.

Goals

As articulated within our Integrated Health Service Plan, the following are the goals identified for Enhanced Community Capacity:

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

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

The Mississauga Halton LHIN's strategic priority of Enhanced Community Capacity, 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:

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

Action Plans	2014/15		2015/16		2016/17	
	Status	%	Status	%	Status	%
1. Develop and implement a Regional Advancement of Community Practice initiative, including a Regional Learning Centre for community providers	In progress	60	Complete	40		
2. Review the findings of the collaborative community capacity planning study and develop implementation plans	In progress	70	Complete	30		
3. Complete the Caregiver Re-Charge Program Research initiative (in partnership with the University of Waterloo)	Complete	50				
4. Increase capacity in long-term care homes to provide enhanced nursing support (Nurse Practitioner) to prevent unnecessary transfers to hospital and reduce hospital length of stay (coordination and transition management in conjunction with access to advanced nursing knowledge)	In progress	40	In progress	30	Complete	30

Action Plans	2014/15		2015/16		2016/17	
	Status	%	Status	%	Status	%
5. Increase capacity of long-term care homes to provide palliative care/end-of-life support to residents avoiding unnecessary transfers to hospital and/or deaths in hospital that could otherwise be cared for in LTC	In progress	50	Complete	50		
6. Improve access to high-quality physiotherapy, exercise and falls prevention classes	Complete	100				
7. Implement improved service commitment for complex care clients and consumers requiring nursing services	Complete	25				
8. Operationalize the service maximum Program Evaluation Recommendations that include Wait at home, Wait at Home Enhanced and Stay at Home	In progress	50	Complete	50		
9. Implement the personal support services wage enhancement effectively and efficiently for applicable health service providers	Complete	100				

Measures of Success

Indicators of success for the Mississauga Halton LHIN will be captured through our MLPA Dashboard (Appendix A) and achievement of the 2014-2015 targets as agreed upon by the Ministry of Health and Long-Term Care and the LHIN. The following developmental/monitoring indicators will also be used to help guide planning and program implementation/evaluation:

1. Regional Learning Centre functioning in development capacity
2. Six priority areas for community practice have work-plans developed and action plans in progress
3. Increased number of service staff that receive enhanced training to understand and assess complex care needs
4. Increased number of people receiving service through local integrated service centers
5. Increased number of caregivers receiving supports such as respite, and training for safe care provision that allow them to safely support their family member at home
6. Reduced number of ED visits best managed elsewhere; reduced number of hospitalizations due to related reasons; reduced number of 30 day readmissions for same diagnosis
7. Increased number of LTCH residents who receive palliative supports

8. Reduced number of ED transfers and hospital admissions from LTCHs; reduced number of application refusals due to lack of palliative resources
9. Increased number of exercise and falls prevention classes available; increased number seniors attending exercise and falls prevention classes
10. Increased number of individuals in priority populations receiving case management and service coordination
11. Implementation of program evaluation recommendations relating to Governance and Engagement, Communication and Education, Service Delivery, Client and Stakeholder Engagement and Experience and Data and Outcomes
12. Ensure that all eligible HSPs are funded as per the Ministry directive and the HSPs have amended agreements with contracted agencies or flowed the enhanced funding to their PSWs

Risks / Barriers to Successful Implementation

- Physical program space to accommodate increased service levels
- Cooperation of non-LHIN funded service partners
- Lack of consistent, robust data collection and management reporting practices
- Community engagement timing
- Inability of service providers to change historic practices and service models
- Resistance to rapid community change

Mitigation Strategies

- Engagement of service partners early to collaborate in action plan development
- Reallocation of funding
- Ensure appropriate level of staff utilized
- Coordinated health human resource planning and recruitment
- Knowledge exchange opportunities for current staff to learn new service models
- Create joint vision for program outcomes
- Develop consistent and standard data collection and management reporting processes for community services
- Ensure collaborative and comprehensive participation with all sectors, health and key stakeholder partners
- Consider social determinants
- Consider prevention and wellness factors in the aging continuum
- Include current state and future state projections considering demographics for 5, 10 and 15 years
- Build existing capacity and consider cost implications prior to implementation
- Capitalize on leading practice models
- Identification of local champions of service change

Key Enablers for Success
• Identification of provincial and local leading practices • Advancements in information technology and management • Utilize Ontario's Change Model for Health System Transformation to achieve successful, sustainable change. • Identification of LHIN wide, standard accountability expectations • Communication strategy for new services • Broad stakeholder engagement, including active patient participation • System access and efficiencies (transportation, eligibility criteria, central access, provider practice and communication for smooth transitions, standard care pathways)

2.4 Optimal Health - Mental and Physical

IHSP Priority Description

Chronic conditions such as heart disease, high blood pressure, diabetes and asthma account for six out of 10 deaths in Mississauga Halton LHIN and one quarter of all acute hospital days. Chronic disease is the leading cause of death in Ontario. We recognize that if we are truly looking to build a high quality, sustainable health care system, attention must be focused on chronic disease prevention and optimizing mental and physical health.

Keeping people healthy is a responsibility that is shared by many, including individuals themselves. By promoting healthy habits and lifestyles we can support the prevention of chronic conditions and assist those people living with chronic disease to enjoy a better quality of life and live longer. The promotion of self-management services and education will allow people to take an active role in the management of their own health. Leveraging partnerships, including the expertise of people with lived experience offers a sustainable, effective mechanism to optimize health.

Working with our partners in public health, local government and other key stakeholders, we can collaborate on prevention strategies and broaden the reach of our messages and education to the general public. People's health concerns need to be addressed in consideration of their living and working conditions, as well as social supports to support achievement of a healthy community.

Current Status

In 2013-2014, the Mississauga Halton LHIN, in collaboration with our health service providers and partners, advanced the priority of Optimal Health – Mental and Physical through a number of achievements which laid the foundation for the coming year:

- The Regional Integrated Chronic Disease Prevention and Management Steering Committee developed a framework for the development of an integrated service strategy. Building upon and leveraging current system resources such as centralized intake for Diabetes Education Services and Self-Management Education, the model supports a regional approach to access and receive services common to the management of chronic conditions.

- With the transition of the Mississauga Halton Diabetes Regional Coordination Centre services within the operation of the LHIN, collaboration with local physicians and endocrinologists, LHIN funded and non-LHIN funded Diabetes Education Centres developed significant service improvements and enhancements over the past year which included:
    - Centralized intake for referral to diabetes education and self-management services
    - Enhanced foot care services for people with diabetes
    - Collaboration between the LHIN and service providers to maximize diabetes service education and supports to primary care physicians
    - Collaboration to develop strategies to deliver diabetes services to priority populations

- In the past year the LHIN has engaged external partners such as the Public Health Departments in Halton, Peel and Toronto as well as local municipal governments to collaborate on chronic disease prevention strategies for development in the next year.

Goals

As articulated within our Integrated Health Service Plan, the following are the goals identified for Optimal Health – Mental and Physical:

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

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

The Mississauga Halton LHIN's strategic priority of Optimal Health – Mental and Physical, 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:

- Ontario's Action Plan for Health Care
- ED/ALC Strategy and Wait Times
- Mental Health and Addictions 10- year strategy
- Seniors' Strategy- *Living Longer, Living Well*
- The *Excellent Care for All Act*
- Ontario Telemedicine Network initiatives
- *Home Care and Community Services Act*

Action Plans	2014/15		2015/16		2016/17	
	Status	%	Status	%	Status	%
1. Develop and implement a regional Integrated Chronic Disease Prevention and Management Strategy	In progress	20	In progress	20	Complete	20
2. Design and implement a regional centralized intake model (commencing with consumers with diabetes and mental health and addictions)	In progress	40	In progress	30	Complete	30
3. Define and implement a Diabetes strategy (within the broader Mississauga Halton LHIN chronic disease prevention and management strategy), that builds clinical capacity for high need areas and supports continuing education for primary care and other health care professionals	In progress	20	In progress	40	In progress	20
4. Implement a Rapid Cycle Pilot Program for diabetes care	In progress	75	Complete	25		
5. Implement a standardized diabetes MedsCheck system across the MH LHIN	In progress	60	Complete	20		
6. Implement an Insulin Initiation Pilot; evaluate and expand if warranted	In progress	50	In progress	25	Complete	25
7. Optimize a common referral form for Diabetes Education Programs	Complete	20				
8. Evaluate and review new “Breathe Better – Live Better Program “ Community COPD Education programs	In progress	80	Complete	20		
9. Establish external partner linkages to develop promotion and prevention of chronic disease strategies	In progress	50	In progress	25	Complete	25

Measures of Success

Indicators of success for the Mississauga Halton LHIN will be captured through our MLPA Dashboard (Appendix A) and achievement of the 2014-2015 targets as agreed upon by the Ministry of Health and Long-Term Care and the LHIN. The following developmental/monitoring indicators will also be used to help guide planning and program implementation/evaluation:

1. Decrease the number and rate of ED visits and hospitalizations related to chronic diseases; decrease the number of readmissions
2. Number of unique individuals being processed through the Diabetes and Mental Health and Addictions Central Intake process
3. Number of primary care physicians who participate in rapid access consult
4. Number of people with diabetes who received preventative foot care
5. Number of Diabetes Education programs using a standardized diabetes MedsCheck system. Number of individuals receiving MedsCheck in pilot program
6. Number of pharmacy participants in the Insulin Initiation Pilot
7. Online referral form template completed and operational
8. Completed evaluation report for the COPD program "Breathe Better – Live Better"
9. Number of cross sector partnerships (beyond health services) to develop and implement strategies and tactics for optimizing health

Risks / Barriers to Successful Implementation

- Resistance to change by health service providers to new service model and integration of services (by whom?)
- Lack of reliable, quality community health data, and methodology for evaluation
- Lack of information technology platforms to allow sharing of integrated information in a secure and timely manner

Mitigation Strategies

- Identify change champions to model and support new service delivery methods
- Collaboration with partner decision support groups to identify standardized indicators and data collection processes
- Identification of current IT platforms that can be leveraged
- Development of common purpose and outcomes for projects
- Phased implementation approach (early adopters) to demonstrate success prior to regional implementation

Key Enablers for Success

- Information management and technological advances
- Utilization of Ontario's Change Model for Health System Transformation to achieve successful, sustainable change
- Communication with stakeholders
- Early adopters of change practices
- Collaboration among agencies
- Accountability management through service accountability agreements
- Leadership among health service providers
- Provider and staff knowledge translation and engagement
- Partnerships

2.5 High Quality, Person-Centred Care

IHSP Priority Description

The Excellent Care for All Act is the cornerstone in enhancing quality health services in Ontario. In alignment with this legislation, the Mississauga Halton LHIN has been working actively to ensure that consumers and caregivers are actively involved and engaged in the planning and development of the services that they receive. The voice of the consumer is paramount to quality improvement and strengthening accountability in the system.

Improving the quality and value of the consumer and caregiver experience is a key focus. Quality measures across sectors through the development of quality improvement plans have raised the importance of quality practices and contributed to the creation of a culture of quality.

We recognize that the services provided within our community must reflect and meet the diverse needs of our population. This includes the provision of services in French for the Francophone community as well as services to meet the unique needs of our Aboriginal community. It also means taking the time to better understand how different communities typically access services and ensure that we are developing strategies to meet their needs in the most appropriate, equitable and respectful manner.

Current Status

- The Mississauga Halton LHIN has been working with identified health service providers to further develop access to French Language services for our Francophone community. Over the last year, the Mississauga Halton LHIN has worked closely with the French Language Health Planning Entity (Reflet Salvéo) to build stronger connections with the community and to better understand the needs of the Francophone community. A project was completed in order to align and identify the key priorities of Reflet Salvéo with the tree LHINs that they support (Mississauga Halton, Central West, and Toronto Central). With this alignment done, the LHIN will continue to work closely with Reflet Salvéo to move forward on key actions to support identified priorities.

- The Mississauga Halton LHIN continued to reach out to Aboriginal stakeholders in our region including the Credit River Métis Council, the Peel Aboriginal Network and Métis Nation of Ontario's Health and Wellness branch. Cultural awareness training of the unique needs of Aboriginal people was put in place for all LHIN staff and Board members. Over the next year, the LHIN will continue to work with Aboriginal leaders to better understand the needs of our Aboriginal communities and work in collaboration to support the availability of culturally services.

- The Mississauga Halton LHIN further developed its Health Equity plan to reduce health disparities and promote equity in access of health services over the past year. The Health Equity System Planning Committee established a working group with health service providers, community agencies and partners, and Francophone and Aboriginal community representatives. Two key initiatives were developed and launched, including a health

equity survey (for health service providers), and a Health Equity Symposium. The overarching goal is to build capacity within the LHIN to understand and address health equity by reducing systemic barriers in access to high quality health care for all by addressing the specific health needs of people along the social gradient, including the most health-disadvantaged populations.

- The Board Quality Committee has defined its "shared purpose" and developed a draft Quality Report for the Mississauga Halton LHIN. The Committee has been educating our Health Service Providers and Governors through the Quarterly Sector Meetings and individual presentations at the Board level with providers' Quality Committees. Health Quality Ontario (HQO) is implementing its Common Quality Agenda and our Quality Report will be aligned with these new system indicators. The MH LHIN HSP Boards and Executive Directors attended a Governance to Governance event where Dr Joshua Tepper, CEO of HQO presented on the Common Quality Agenda and the LHIN Board engaged the providers around common quality indicators for the LHIN, definitions of quality, and quality improvement plans (QIPs) at a community provider level.

- HQO has rolled out QIPs for CCACs effective 2014-15 and for long-term care homes effective 2015-16. The LHIN is determine what supports might be need for some of our long-term care homes to ensure that they submit "practice" QIPs for the 2014-15 fiscal year.

- In the past year the development of common indicators for client satisfaction have been introduced into the accountability agreements for the hospital and community sectors. The introduction of these elements will allow the comparison of results across the service sectors.

Goals

As articulated within our Integrated Health Service Plan, the following are the goals identified for High Quality Person-Centred Care:

- Continue to support and foster a quality culture across the continuum of care
    - Implement the Excellent Care for All Act at a local level to embed a culture of quality within all LHIN health service providers
    - Develop mechanisms for tracking quality of care, safety and system effectiveness as it pertains to desired outcomes
    - Implement consistent care pathways and standardized care plans (i.e. discharge plans)
    - Use scientific evidence to support effective utilization of health care dollars
- Value people's experiences to support system improvement
    - Identify person experience metrics and use to guide service improvement and development
    - Ensure services are flexible to meet consumer and caregiver needs
    - Include people with lived experience as active members of planning and quality improvement teams

- Develop a LHIN-wide customer service focused approach

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

The Mississauga Halton LHIN's strategic priority of Optimal Health – Mental and Physical, 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:

- Ontario's Action Plan for Health Care
- Health Quality Ontario Common Quality Agenda
- The *Excellent Care for All Act*
- *French Language Services Act*
- Pan-LHIN Aboriginal/First Nations priorities
- Provincial Health Equity Impact Assessment

Action Plans	2014/15		2015/16		2016/17	
	Status	%	Status	%	Status	%
1. Revise Board Quality scorecard to reflect Health Quality Ontario's Common Quality Agenda	Complete	100				
2. Support CCAC and Long-term care homes in their required submissions of Quality Improvement Plans (QIPs)	Complete	100				
3. Require selected community health service providers to submit Board approved Quality Improvement Plans	In progress	90	Complete	10		
4. Implementation of Health Quality Ontario's (HQO) Ontario Health Technology Advisory Council recommendations	In progress	50	Complete	20		

Action Plans	2014/15		2015/16		2016/17	
	Status	%	Status	%	Status	%
Finalize OCAN with all mental health and addictions health service providers	In progress	90	Complete	100		
Design and Implement the Health Equity plan across the Mississauga Halton LHIN	In progress	25	In progress	25	Complete	25
Design and implement Mississauga Halton LHIN specific elements and joint elements of the 2014-15 Joint Annual Action Plan (JAAP) (alongside Reflet Salvéo, Central West LHIN and Toronto Central LHIN)	Complete	100				
Ensure the Mississauga Halton LHIN is meeting the requirements of the FLSA in its active offer of French Language Services	In progress	70	Complete	30		
Gain greater understanding of the FLS capacity among health service providers and work with identified HSPs and those with capacity to improve the active offer of French Language Services	Complete	100				
Implement Mississauga Halton LHIN Aboriginal Cultural awareness training	Complete	100				
Build partnerships to develop Aboriginal specific programs and services within some MH LHIN health service providers	In progress	50	Complete	50		
Develop and implement a consistent approach to community engagement within the MH LHIN	Complete	100				

Measures of Success

Indicators of success for the Mississauga Halton LHIN will be captured through our MLPA Dashboard (Appendix A) and achievement of the 2014-2015 targets as agreed upon by the Ministry of Health and Long-Term Care and the LHIN. The following developmental/monitoring indicators will also be used to help guide planning and program implementation/evaluation:

1. MH LHIN Board quality scorecard revised to align with HQO's Common Quality Agenda
2. Enhanced quality of care across CCAC and LTCHs; Measures identified in quality improvement plans are met

3. Increase update in number of health service providers using the Health Equity Impact Assessment Tool during their planning activities standard collection and analysis of health equity information by health service providers
4. Identification of capacity of health service providers to deliver services in French with the aim to increase the number of health service providers who are able to provide services in French
5. Increase capacity of Mississauga Halton LHIN health service providers to offer French Language Services
6. Development of specific programs in partnership with Aboriginal leaders focused on better meeting Aboriginal health needs
7. Increased number of HSPs that have developed Aboriginal specific programs and services
8. Development of a Mississauga Halton LHIN framework and strategy for community engagement

Risks / Barriers to Successful Implementation

- Level of health service providers' knowledge, capacity and capability for quality improvement
- Time commitment for agencies to develop QIPs
- Lack of standardized quality metrics available for community providers as well as at the system level
- Lack of commitment to change and accept new ideas
- Lack of awareness of health equity issues and poor understanding of health equity components by service providers
- Time required for completion of standardized client assessments

Mitigation Strategies

- Identify community health service provider quality requirements within their service accountability agreements
- Ensure there is quality improvement support for health service providers and that they are aware of the multitude of resources available
- Provide education sessions on the Excellent Care for All Act and Governance for Quality to health service providers and their Boards
- Training and education to enhance Health Equity knowledge of the health service provider agency staff
- Identify champions to assist with the ongoing implementation of the OCAN assessment tool
- Development of collaborative communities of practice

Key Enablers for Success

- HQOs Common Quality Agenda
- Implementation of QIPs for the CCAC and Long-Term Care Homes
- Utilization of Ontario's Change Model for Health System Transformation to achieve successful, sustainable change
- Timing for the development of new accountability agreements (H-SAA and M-SAA)
- Identification of early adopters
- Board Quality committee and Mississauga Halton LHIN Governance to Governance structure
- Technology and information management system development

3.0 LHIN OPERATIONS AND STAFFING PLANS

LHIN OPERATIONS SPENDING PLAN				
LHIN Operations Sub-Category ($)	2013/2014 Actuals	2014/15 Planned Expenses	2015/16 Planned Expenses	2016/17 Planned Expenses
Salaries and Wages	3,136,910	3,315,360	3,315,360	3,315,360
Employee Benefits				
HOOPP	304,171	350,493	350,493	350,493
Other Benefits	386,378	389,524	389,524	389,524
Total Employee Benefits	690,549	740,016	740,016	740,016
Transportation and Communication				
Staff Travel	23,317	22,000	22,000	22,000
Governance Travel	8,559	12,000	12,000	12,000
Communications	30,248	35,000	35,000	35,000
Other Benefits				
Total Transportation and Communication	62,124	69,000	69,000	69,000
Services				
Accommodation	247,405	303,642	303,642	303,642
Advertising	2,717	5,000	5,000	5,000
Banking		-	-	-
Community Engagement		-	-	-
Consulting Fees	100,088	209,922	209,922	209,922
Equipment Rentals	20,882	23,989	23,989	23,989
Insurance	7,209	8,800	8,800	8,800
Governance Per Diems	67,821	90,000	90,000	90,000
LSSO Shared Costs	347,093	347,098	347,098	347,098
Other Meeting Expenses	25,544	30,000	30,000	30,000
Other Governance Costs	31,954	45,000	45,000	45,000
Printing & Translation	8,706	39,973	39,973	39,973
Staff Development	56,697	28,000	28,000	28,000
LHINC	47,500	47,500	47,500	47,500
Other Services	33,407	24,286	24,286	24,286
DRCC INTAKE PROGRAM - Transfer to HHC	278,497	-	-	-
ONE-TIME Start-up COST (DRCC)	36,316	-	-	-
Total Services	1,311,836	1,203,210	1,203,210	1,203,210
Supplies and Equipment				
IT Equipment	9,482	25,732	25,732	25,732
**Office Supplies & Purchased Equipment	81,064	51,000	51,000	51,000
Total Supplies and Equipment	90,546	76,732	76,732	76,732
LHIN Operations: Total Planned Expense	5,291,965	5,404,319	5,404,319	5,404,319
Annual Funding Target	5,490,653	5,404,319	5,404,319	5,404,319
Variance	(198,688)	(0)	(0)	(0)
NOTE: Budget and FTE's reflect Operations and DRCC				
DRCC:	1,347,626	1,288,626	1,288,626	1,288,626
Does not include capitalRevenue and depreciation of assets.				
**The cost of capital purchase in the fiscal year 2013/ 2014 is reported on the line *office supplies nad purchases equipment*				

LHIN STAFFING PLAN (FULL-TIME EQUIVALENTS)				
Position Title	2013/14 Actuals Mar. 31/14 FTEs	2013/14 Forecast FTEs	2014/15 Forecast FTEs	2015/16 Forecast FTEs
CEO	1	1	1	1
Senior Director, Finance & Risk	1	1	1	1
Senior Director, Health System Performance	1	1	1	1
Senior Director, Health System Development & Community Engagement	1	1	1	1
Manager of Corporate & Business Services	1	1	1	1
Executive Lead, Health System Performance	1	1	1	1
Executive Lead, Health System Development	1	1	1	1
Executive Lead, Primary Care	1	1	1	1
Executive Lead, Funding & Allocation	1	1	1	1
Director, Decision Support & Information Managemer	1	1	1	1
Director, Governance, Quality & Communication	1	1	1	1
Executive Assistant	3	2	2	2
Administrative Assistant	3	4	4	4
Receptionist/Corporate Services Assistant	1	1	1	1
Lead Health System Development & FLS	1	1	1	1
Senior Lead Funding & Allocation	1	1	1	1
Senior Lead Health System Development	2	3	3	3
Senior Lead Health System Performance	5	5	5	5
Financial Analyst	1	1	1	1
Decision Support & Information Lead	2	2	2	2
Decision Support & Information Mgmt. Analyst	1	1	1	1
Senior Lead Communications	1	1	1	1
HSFR Medical Lead	1	1	1	1
Diabetes Medical Lead		1	1	1
Special Projects Coordinator	1	1	1	1

4.0 COMMUNICATIONS

4.1 Communication Plan

Objectives

Business Objective:

The Mississauga Halton LHIN 2014-15 Annual Business Plan operationalizes the goals contained in the LHIN's 2013-2016 Integrated Health Services Plan: *Partnering for a Healthier Tomorrow* 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,

- Accessible and Sustainable Health Care
  - Improve access to services to improve consumer flow, quality and safety
  - Support consumers, families and health care professionals to navigate the health care system
  - Improve sustainability of the health care system
- Family Health Care When You Need It
  - Improve access to family health care
  - Increase linkages between family health care and other health care providers to improve communication, coordination and integration across the continuum of care
- Enhanced Community Capacity
  - Enable people to stay in their homes longer
  - Provide integrated services that bring care closer to home
- Optimal Health - Mental and Physical
  - Increase healthy habits and prevention of disease
  - Build partnerships for healthy communities
- High Quality Person-Centred Care
  - Support and foster a quality culture across the continuum of care
  - Value people's experiences to support system improvement
  - Apply a health equity lens for the delivery of health care services

Communications Objective:

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

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

- Guide the communications of the Mississauga Halton LHIN (Board and staff) and health service provider partners involved in initiatives contained in the 2014/15 Annual Business Plan to ensure target audiences are reached and messages are clear.

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

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

- Inform and update stakeholders on the progress of initiatives.

Context

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

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

- The MH LHIN's 2013-16 IHSP and the initiatives laid out in this Annual Business Plan are strategically aligned with government directions and priorities and recognize the joint accountability of the ministry and

LHINs to serve the public interest and effectively oversee the use of public funds.

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

Target Audience

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

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

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

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

- Media

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

Strategic Approach

- Provide information on performance and progress– document successes and share it;

- Showcase and communicate to stakeholders including the public, specific examples of program accomplishments and how they benefit our region. These examples will position the LHIN as a valued key player within the transformation of Ontario's health system and as the lead in health system transformation in Mississauga Halton region;

- Develop and leverage opportunities to build our reputation and establish credibility including encouraging third-

party experts to express publicly their opinion and comments on Mississauga Halton LHIN program and operational achievements;

- Stakeholders understand the rationale for change, the transformational model and the plans for implementation;
- Leaders are engaged to champion change throughout the region;
- Provide tools that help ambassadors explain the value of the LHIN;
- Align the health service providers to the shared vision, mission, values and goals of Mississauga Halton LHIN as described in our Integrated Health Service Plan and Annual Business Plan;
- Mitigate communications risks of negative publicity by proactive planning of risk reduction.

LHIN Key Messages

- Ontario is shifting the focus of its health care system to revolve around the person. We have a plan to ensure Ontarians have access to high quality care and a sustainable health system for years to come. By organizing our system differently and focusing on the medical evidence, we will provide Ontarians with better care and better value for tax dollars.

  Through these changes, we expect to see:
  - Reduced wait times and faster access to family doctors
  - Fewer unnecessary visits to the emergency room and re-admissions to hospital
  - Patients receiving care at home or in the community instead of in a hospital

  How are we transforming the health care system?
  - Partnering with the sector and enabling them to play an active role in how the system will change.
  - Strengthening community agencies to support providers and encourage integration around the patient's needs.
  - Health care funding will be determined based on the best evidence and will follow the patient.

  What can we expect from these changes to the healthcare system?
  - A system built for patients by the health care providers and leaders closest to them.
  - A health care system that integrates providers around patients to deliver better outcomes.

- 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;
  - The Mississauga Halton LHIN pioneered programs such as Supports for Daily Living which is regionally integrated across eight local providers and that spawned like initiatives across the province and beyond.

- 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 promotes a better patient experience;
  - Creation of campaigns such as Feel Better Faster – a regional approach to planning for service

availability and coverage over the holidays developed in collaboration with primary care providers, pharmacy, schools, community services, and acute care hospitals to make sure residents get the right treatment and at the right time and place.

- By talking and listening to local health care providers and community residents, and through careful strategic planning, the Mississauga Halton LHIN identifies and funds local initiatives;
  - Though Caregiver Recharge primary caregivers are receiving the much needed support identified through the Integrated Health Service Provider engagement including adequate training, respite and coordination of service.

- The Mississauga Halton LHIN is committed to making the experience of care more seamless and easier to navigate;
  - The Mississauga Halton LHIN has committed through the Caregiver First Strategy, Health Links, and through initiatives like Mental Health and Addictions System Access Model (SAM) to build a health care system that integrates providers around patients to deliver better outcomes.
  - Providing support in the community such as COPD education at convenient community locations that are easily accessible, on a public transit route and offer free parking.

Tactics

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

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

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

Evaluation
Success of the communication plan will be measured with the following: • Participation levels in engagement sessions and LHIN-wide committees • Key stakeholders are quoted using information from engagement sessions or other communiques. • The number of newspaper articles mentioning the Mississauga Halton LHIN • The volume and tone of editorial coverage • On-line surveys • Evaluation forms at face-to-face engagement sessions • LHIN spokesperson is quoted in key media outlets • You tube and website traffic • Focus Groups

4.2 Community Engagement

The Mississauga Halton LHIN is committed to engaging our community to understand their needs for health care service and their experiences accessing service to be able to include our residents as active partners to improve the services they receive. By listening to their stories, including users of our health care services in our planning processes and building upon their suggestions we make our service system better. Evidence of our reach out to the community to receive their input was demonstrated through the development of our Integrated Health Services Plan for 2013 – 2016 where we engaged with over 1700 individuals.

The Mississauga Halton LHIN has provided staff with formal training in community engagement to ensure that it is a regular process within the planning, monitoring and evaluation of services within our area. Training has also been provided to our local Health Service Providers to ensure that they also include community engagement within their normal work practices.

Within the Mississauga Halton LHIN community engagement with the general public and formal stakeholders is seen as a natural component of doing business and not just an activity that occurs once or twice a year. The MH LHIN incorporates a number of techniques that range from broad based open forums to highly focused issue specific round tables depending upon the nature of engagement required. We also utilize our many existing committees and networking tables with our local health service providers and stakeholders to support our engagement activities.

e-Health

Engagement with our local health service providers, neighboring LHINs through the Central Ontario cluster and with provincial e-Health groups is critical in order to develop the information technology and information

management systems needed to support a quality service system. Engagement to support development and implementation of a centralized intake model, integrated patient discharge records, the resource matching and referral Provincial Referral Standards system and integrated assessment records are examples of activities where e-health engagement is critical. Effective e-Health solutions to enable improved communication between service providers are essential to support the coordination of services provided for people in our community. This will be a key area of attention as we move forward with the development of Health Links in our communities.

Francophone Community

The Mississauga Halton LHIN is home to over 35,000 francophone people as defined under the new Inclusive Definition of Francophones (IDF). In order to meet our commitments under the Local Health Integration System Act (LHSIA), engagement with our Francophone community is supported through work with our local French Language Health Planning Partner, Reflet Salvéo.

Aboriginal Community

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

APPENDIX A:

Ministry-LHIN Performance Agreement Dashboard 2014-2015

MISSISSAUGA HALTON LHIN - PERFORMANCE INDICATORS
FY2014/15 - BASELINES AND TARGETS

PI No.	Performance Indicator	Baseline[#]	Performance Target[#]
1: Access to healthcare services			
1.0	90th percentile ER length of stay for admitted patients	30.75	28.00
2.0	90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients	5.95	7.00
3.0	90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	3.60	4.00
4.0	Percent of priority IV cases completed within access target (84 days) for cancer surgery	95.25%	90.00%
5.0	Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	98.00%	90.00%
6.0	Percent of priority IV cases completed within access target (182 days) for cataract surgery	95.35%	90.00%
7.0	Percent of priority IV cases completed within access target (182 days) for hip replacement	96.56%	90.00%
8.0	Percent of priority IV cases completed within access target (182 days) for knee replacement	90.64%	90.00%
9.0	Percent of priority IV cases completed within access target (28 days) for MRI scans	30.10%	45.00%
10.0	Percent of priority IV cases completed within access target (28 days) for CT scans	83.02%	80.00%
2: Integration and coordination of care			
11.0	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	11.34%	10.50%
12.0	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	36.00	21.00
3: Quality and improved health outcomes			
13.0	Readmission within 30 Days for Selected CMGs**	13.84%	13.50%
14.0	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.23%	16.00%
15.0	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	27.02%	21.00%

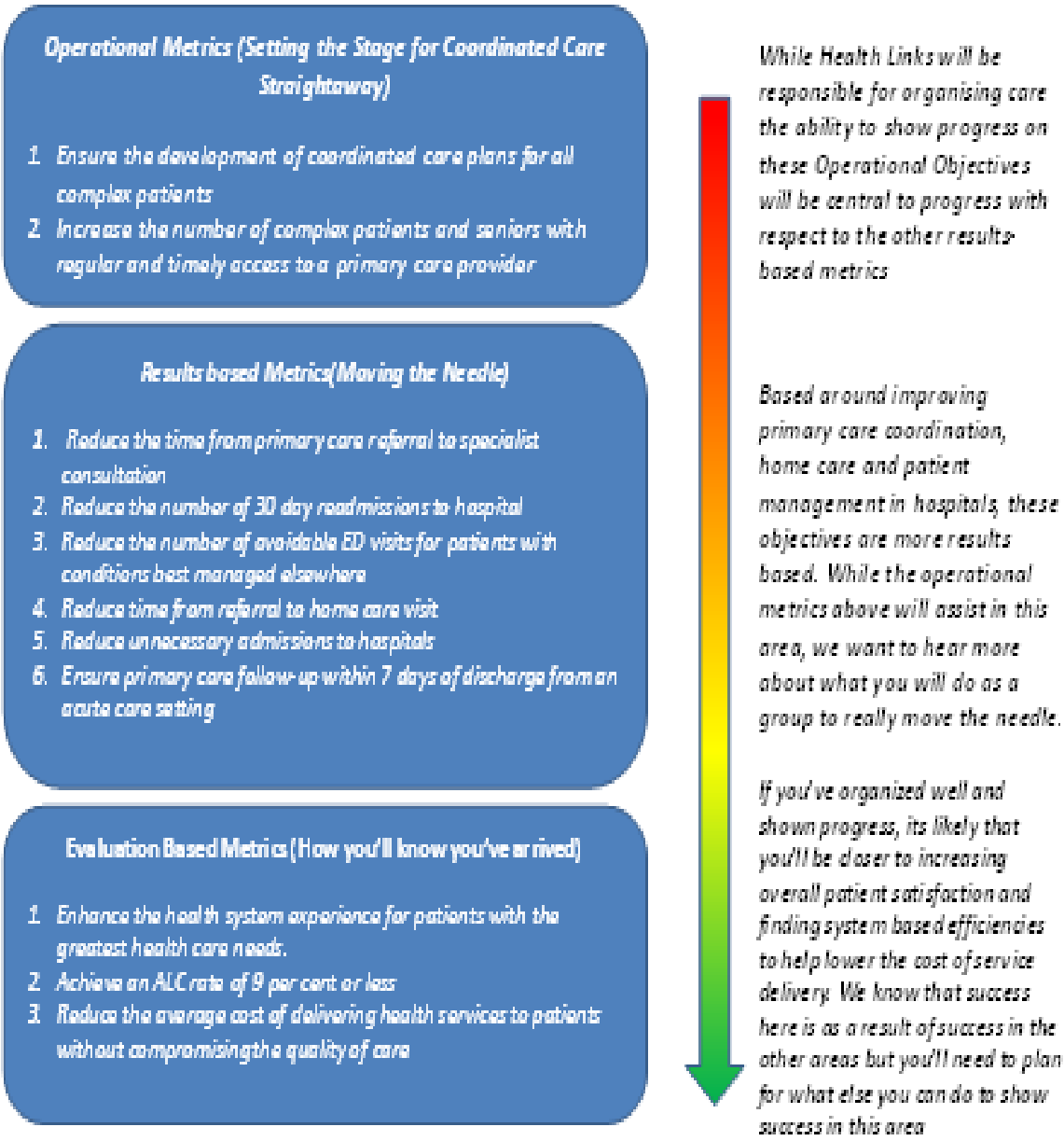
[#] Baselines are actual FY 13/14 performace, except for * and ** below

* Based on most recent four quarters of data (Q4 2012/13 - Q3 2013/14) due to availability

** Based on most recent four quarters of data (Q3 2012/13 - Q2 2013/14) due to availability

[##] As per MLPA agreement between LHIN and Ministry

APPENDIX B: Ministry Health Links Performance Measures 2014-2015



To ensure that the success of Health Links initiative is measurable and sustainable, a common and consistent definition for high/complex users from an operational and management reporting perspective will need to be articulated from the Provincial level as these indicators are more fully defined.