Mississauga Halton **LHIN**

# Mississauga Halton
# Local Health Integration Network

# Annual Business Plan

## April 1, 2010 – March 31, 2011

Ontario
Local Health Integration Network

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Mississauga Halton **LHIN**

January 31, 2010

J. Kenneth Deane
Assistant Deputy Minister
Health System Accountability and Performance Division
Ministry of Health and Long-Term Care
80 Grosvenor Street, 5th Floor, Hepburn Block
Toronto ON M7A 1R3

Subject: Annual Business Plan 2010/11 – Mississauga Halton LHIN

Dear Mr. Deane:

On behalf of the Board, it is my pleasure to submit to you our Annual Business Plan (ABP) for 2010 – 2011. This plan outlines initiatives planned and underway in the Mississauga Halton LHIN to implement our Integrated Health Service Plan (IHSP) for 2010 - 2013. As the first ABP for the new IHSP, it is critical that this plan lay a solid foundation for the work to come in the next two years, as well as build on the groundwork achieved in our initial IHSP and past business plans.

This plan 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 the public. It further recognizes the health care priorities articulated by the Ministry of Health and Long-Term Care related to reducing wait times in emergency departments, reducing the amount of time patients spend in alternate level of care beds, improving access to integrated diabetes care and integrating mental health and addictions services to better serve patients' needs.

We are confident that this plan positions our 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*. We look forward to feedback on our ABP.

Yours truly,

John Magill
Chair, Board of Directors

c: Board of Directors

Ontario
Local Health Integration Network

## Purpose

The Annual Business Plan (ABP) is prepared by the Mississauga Halton Local Health Integration Network (MH LHIN) to advise the Ministry of Health and Long-Term Care (MOHLTC) on how it intends to meet its planning and performance requirements as well as how it intends to fulfil its *Integrated Health Service Plan* (IHSP). This 2010/11 Annual Business Plan identifies the current and anticipated activities by providing detailed goals and objectives for spending the upcoming year's funding allocation.

For the 2010/11 ABP, the MOHLTC set minimum content requirements and the use of templates to standardize ABP submissions from all LHINs. The four distinct components of the ABP are:

- **Context** - LHIN mandate, strategic priorities, and assessment of issues facing the LHIN.
- **Core Content** - Goals, objectives, performance measures and targets.
- **LHIN Operations** - Summary of staff numbers and proposed capital expenditures.
- **Communication Strategy** - Details of community engagement specific to the ABP.

## Mandate and Strategic Directions

The Mississauga Halton Local Health Integration Network (MH LHIN) is a crown agency responsible for the planning, integration and funding of hospitals, long-term care homes, mental health and addictions agencies, community support services, and the Mississauga Halton Community Care Access Centre. These LHIN funded health service providers negotiate and sign accountability agreements with the MH LHIN.

The reporting between the Ministry of Health and Long Term Care (MOHLTC) and the MH LHIN is based on the legal requirements included in the *Local Health System Integration Act,* 2006 (LHSIA), the Memorandum of Understanding (MOU) between both parties and by the Ministry-LHIN Accountability Agreement (MLAA). It is grounded in the government directives such as the Agency Establishment and Accountability Directive (AEAD). This directive includes the requirements and processes for agency business planning.

### *Strategic Directions*

The strategic directions that guide our activities include:

- Improving access, quality and sustainability of the health system.
- Creating LHIN-wide regional programs.
- Prevention and management of chronic conditions.
- Integrating mental health and addictions services.
- Enhancing seniors' health, wellness and quality of life.
- Strengthening primary health care.

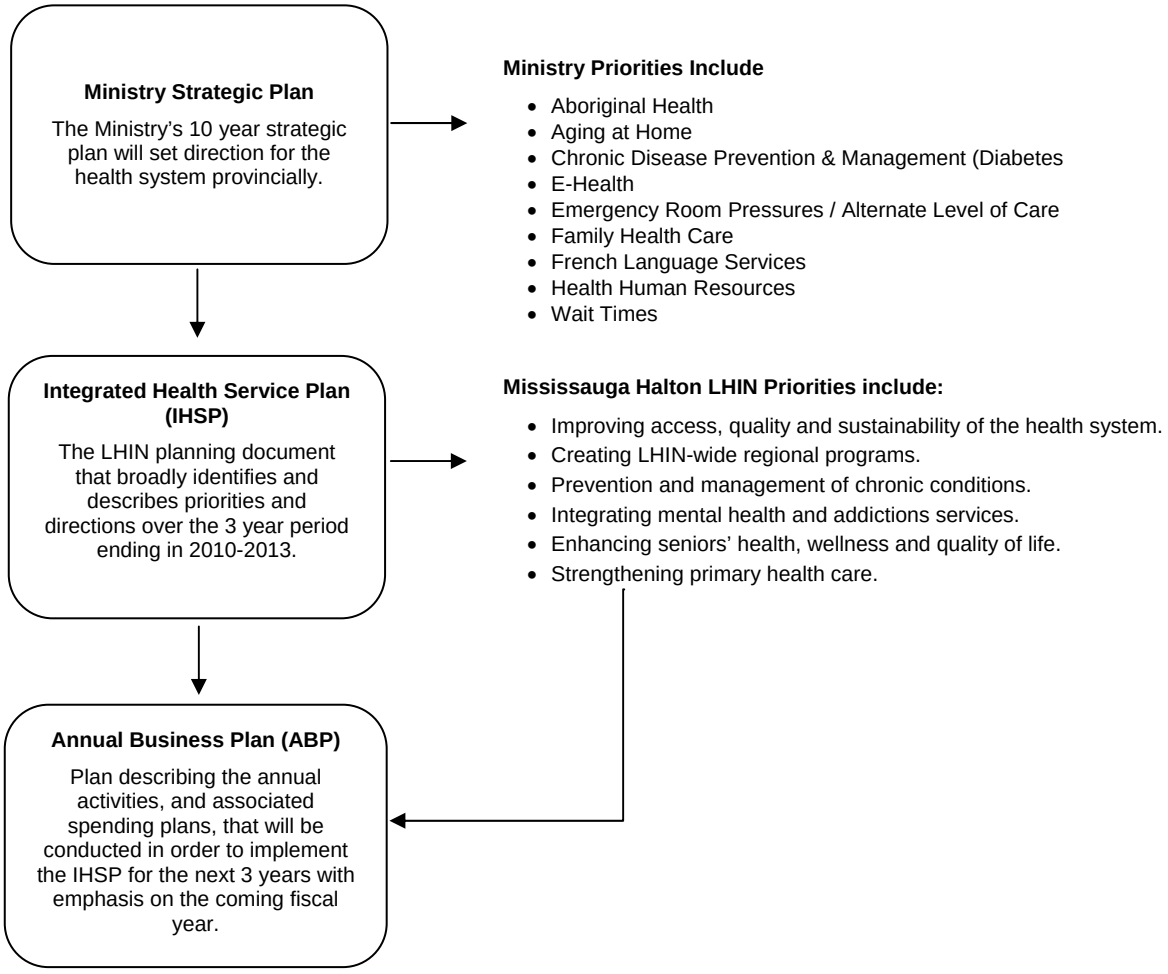
The MH LHIN has identified several enablers that will support our strategic priorities. These include:

- Partnerships for collaboration.
- eHealth.
- Transportation.
- Engaging the public about their personal health.
- Health human resources.

As eHealth is a critical enabler that crosses all of our strategic priorities, we specifically highlight the actions we are taking to implement our eHealth initiatives.

The following table illustrates the relationship between the priorities outlined in the MH LHIN's *Integrated Health Service Plan* and the priorities of the Ministry of Health and Long-Term Care.

Table 1
Relationship Between MOHLTC Priorities & MH LHIN Priorities



# Overview of Current and Forthcoming Programs / Activities

### *Health Service Providers*

Mandated to plan, fund and integrate local health services, the MH LHIN does not directly provide health care services, but works with health service providers, communities and the public to set priorities and plan health services across the LHIN. The MH LHIN is responsible for allocating funding for the following health service providers:

- Hospitals (3);
- Community Care Access Centre (CCAC) (1);
- Mental health and addictions services (12);
- Long-term care homes (27); and
- Community support services (34).

### *Current Investment Initiatives*

The MH LHIN investments to-date and over the next two years are aimed at directly impacting on improving the ER wait times and reducing the alternate level of care (ALC) days.

The MH LHIN has a comprehensive set of initiatives that focuses investments on improving ER Treatment Times and reducing Alternate Level of Care (ALC). These initiatives will:

- Reduce the percentage of ALC patient days in hospitals;
- Reduce ER Wait time to target;
- Sustain the percentage of ER visits that could have been managed elsewhere;
- Reduce or maintain the number of people on the waitlist for Long Term Care Homes; and
- Reduce the median wait time to Long Term Care Homes.

We have strategically invested in initiatives through the Aging at Home Investments to achieve these expectations and will continue to do so in 2010/11. Specifically, we will:

- Implement transitional capacity.
- Continue to increase community capacity as alternatives to LTC Homes to directly impact on referrals from ERs and post acute care (e.g. Supports for Daily Living (SDL) Services; “Wait at Home” from Hospital for LTC Beds; LHIN-Wide Regional Geriatric Program).
- Increase support to CCAC, LTC homes and Community sectors to manage the frail and “high” need seniors and reduce reliance on ER – a major transformation.
- Focus on diversion and prevention initiatives for 75+ seniors who are the largest driver of intensity of care in ERs and constitute the majority of ALC patient days in hospital (e.g. Adult Day Services; Increasing LTC Home capacity; Palliative Care and Hospice; Better use of Complex Continuing Care and Rehabilitation Resources).

In addition to Aging at Home investments, the MH LHIN has made, and will continue to make, strategic investments to increase ER capacity and performance in 2010/11. This includes:

- ER process improvements through Pay for Results.
- Reduction of ambulance off-load.
- Growth funding for ER volumes in high growth communities.
- Improving throughput in complex continuing care and rehabilitation to reduce the ALC Days, and thus reduce the ER wait times.

Our strategies for going forward in the next two years to reduce ER and ALC include:

- Fully implementing and monitoring performance of several innovative approaches to support seniors to "age at home" – e.g. for SDL complete a comparison with baseline (2008) after 18 months.
- Optimizing and increasing the capacity of community services within the LHIN to address aging.
- Reducing reliance on LTC beds and hospitals.
- Engaging our seniors' and their families/caregivers to understand their needs to age at home with dignity.
- Preventive and wellness services to reduce unnecessary ER visits or pre-mature institutionalization.
- Culturally sensitive options to meet needs of the LHIN with one of the most diverse populations.

### *Forthcoming Initiatives*

The 2010/11 ABP provides high level details on specific plans and projects that will advance the following IHSP priorities for change:

- **Improving access, quality and sustainability of the health system** – with a focus on reducing Emergency Room treatment times/alternate level of care days, and continued transformation of the community sector.
- **Creating LHIN wide regional programs** – with a focus on improving access, efficiency and quality of care.
- **Prevention and management of chronic conditions** – with a focus on improving access to integrated diabetes services and chronic kidney diseases services across the MH LHIN.
- **Integrating Mental Health and Addictions Services –** with a focus on improving access to services, early diagnosis and treatment, and reducing ER visits and hospital stays.
- **Enhancing Seniors' Health, Wellness, and Quality of Life** – with a continued focus on transforming the community services to support "at risk" seniors to live at home as long as possible.
- **Strengthening Primary Health Care** – with a focus on increasing family physicians' use of electronic medical records and developing stronger linkages with family physicians to collaborate directly on priority initiatives.
- **Integration of E-Health** – with a focus on enhancing the use of technology and improving LHIN wide sharing and exchange of patient information among providers along the continuum of care.
- **Engagement with Aboriginal People** – The MH LHIN will work with our Aboriginal communities in collaboration with our neighbouring LHINs to better understand and address issues of access to health care services.
- **Ensuring French Language Services** – with a focus on improving access to French language health services (FLHS) for Francophone residents of the MH LHIN.

## Drivers of System Change

The MH LHIN undertook extensive community engagement activities and an environmental scan in 2009 to identify gaps and opportunities in our health care system as part of the planning for its 2010-2013 Integrated Health Service Plan (IHSP). Based on the environmental scan, the following drivers are exacerbating existing service delivery challenges in the Mississauga Halton LHIN.

- Demographic trends (immigration and increased diversity).
- Growth of the population (significant in some areas of the LHIN including Milton, leading to increased demand for services).
- Aging population.
- More medically complex patients.

In addition, the following issues affect provision of health services:

### *Economy*

Ontario's current economic conditions and projected deficits for the three years may impact on direct service delivery. This creates the opportunity for accelerated transformation of programs and services across the MH LHIN. Our investments will be timely, targeted, and fiscally responsible.

### *Hospital Capacity*

The LHIN has benefited from significant capital investments and is moving forward on development of the new Oakville Hospital site as well as redevelopment at The Credit Valley Hospital and the Trillium Health Centre.

However in the next year, while some of this hospital redevelopment takes place, there is a need for increased capacity of ER/critical care/OR across the LHIN. A number of actions are in place to examine operational and utilization improvements across the hospitals. The challenge is some of the new capital investments that would help to alleviate the current pressures will not be in place for a few more years, meaning current demand will continue to outpace capacity and put further pressures on the system.

### *Pandemic Influenza*

The demand for critical care hospital admissions across the LHIN resulting from the rapid rise in the number of pandemic (H1N1) 2009 influenza cases is not yet fully known. ER visits, hospitalization rates, demand for ICU beds and the need to implement surge capacity will be important to understand as a result of this pandemic to better plan for services in the future. What we do know is when the healthcare community is mobilized to deal with such events; our ability to achieve some of the actions we have identified for 2010/11 may be slowed when all health care resources are focused on such critical events.

### *Emergency Room Pressures*

Higher acuity visits (CTAS 1 to 3) are increasing at a greater rate than lower acuity (CTAS 4 & 5) at most sites. This may put increase pressure on ED through Q1.

# Detailed Plans for the Local Health System

The goals and objectives for the priorities for change have been extracted from the LHIN's Integrated Health Service Plan (IHSP) and are presented in this Annual Business Plan. The goals and objectives are long term and may require 3 or more years to achieve.

The specific actions identified in this plan are intended to advance the IHSP goals and objectives over the coming year. Each of the IHSP strategic priorities are presented along with a description of the current status, successes, action plans for 2010/11, expected impacts, and risks.

In addition to the IHSP priorities, this plan includes specific actions related to Aboriginal and Francophone initiatives, as well as eHealth.

The following 2010/11 ABP priorities are described in great detail:

# PRIORITY 1

## IMPROVING ACCESS, QUALITY AND SUSTAINABILITY OF THE HEALTH SYSTEM

### *Description*

This priority is synergistic with the provincial mandate to improve health system performance in two areas: reducing treatment times in emergency rooms and reducing the number of Alternate Level of Care (ALC) days.

Ontarians want timely access to emergency room care. In order to improve emergency room treatment time, the Ontario government has set clear targets for reducing the amount of time patients spend waiting in emergency rooms (ERs) – these targets are outlined below. One way to reduce ER wait times is to make sure that the public, family doctors, and ER doctors and nurses have up-to-date information about the non-emergency health services available in the community.

Our focus will continue to be on reducing time spent in hospitals by improving appropriate use of hospital beds and ensuring people are receiving the right care in the right setting. Building on our Home First philosophy, we plan to continue the transformation of community services to increase capacity that facilitates the timely flow of patients back to the community.

Our focus on improving access will also be achieved through implementation of our Health Equity Plan. The goal of this plan is to reduce health disparities and differential outcomes in the MH LHIN. Our vision for health equity will address the great diversity in our LHIN. The MH LHIN will strive to reduce health disparities as a shared responsibility with its health service providers by integrating health equity into strategies and activities that fall within our mandate and influence. We will know that we have been successful when the local population's health and wellness are excellent and everyone, particularly those with the greatest need have access to the right care, at the right time and in the right place.

### *Current Status*

**Emergency Room Treatment Times**
The MH LHIN has observed improvements in the 2009/10 ER wait times as a result of the ED Pay for Results Program. There has been a 15% reduction in overall wait time in Emergency Departments across the LHIN, from 10.2 hours to 8.6 hours (April 2008 to July 2009).

In 2009/10, the Pay for Results (P4R) program was expanded to include all hospital corporations (Trillium Health Centre, Halton Healthcare services (2 sites) and Credit Valley Hospital), for a total of 4 hospital sites. Average time spent in ER for high acuity patients in Q1 09/10 was down considerably to 12.2 hours for admitted patients. This notable improvement is in spite of the increase number of CTAS 1-3 attending ER in Q1 09/10. This demonstrates great improvement in ER operational flow and access to inpatient beds. Time spent in ER for low acuity patients has remained stable in Q1 09/10 compared to all quarters of 08/09.

Inpatient and flow improvements throughout the hospital are being achieved and contributing to the throughput of admitted ER patients. This is happening as a result of improved patient management by patient flow coordinators, better utilization management efforts with CCAC and discharge planning; and improved patient care treatment planning provided by Nurse Practitioners.

**Alternate Level of Care**
The percentage of ALC days has declined significantly in Q1 09/10 compared to Q2,3,4 of 08/09. The value of 7.61% is well below the target for the MH LHIN of 8.870% and for the province at 9.46%. Successful community investments has lead to more appropriate post hospital discharge of ALC patients to home care and community programs. The percentage ALC days for Q2 09/10 is 8.8% meeting the target. The MH LHIN has created a process to audit ALC designated hospitalized patients to assess the implementation and sustainability of the Home First Approach.

**Transformation of Community Sector**
At the forefront of LHIN activities has been a dedicated focus on appropriate level of care (ALC) activities and improved emergency wait times. Many of the investments made in ALC initiatives are contributing to more appropriate use of emergency departments by enhancing and increasing the capacity of community based services. Several new initiatives were introduced through the collaborative efforts of health service providers to enhance community support services:

- Supports for Daily Living (helping seniors to continue living independently at home);
- Restore Program (helping patients regain physical functioning, help avert unnecessary admissions to long-term care and support adults to continue living independently at home as long as possible by bridging a gap between hospital and home care).
- Home First (all efforts made to discharge patients from hospital back to home).
- Enhanced home care services.

These initiatives are resulting in significant improvements in discharging patients home rather than having them admitted to long-term care.

## *Successes of the Past Year*

**Supports for Daily Living**

- Referrals to SDL programs are increasing as processes have been centralized and standardized with the CCAC.
- Demonstrated impact of program now emerging. As of December 2009:
    - 111 clients were diverted from LTC Home;
    - 659 ER visits were diverted;
    - 964 days were reduced from the hospital length of stay;
    - 21 clients came off the LTC wait list.

**CCAC**

- Implementation of the Home First, Wait at Home and Stay at Home strategies – successful movement of clients from hospital into the community – assisting in alleviating ALC pressures by providing 390 patients with intense home care services.
- Active participation in working with all health care sectors to influence and/or make the changes necessary to sustain health system transformation initiatives.

**The Restore Program**
Provides short-term care to support a return to independent living following a stay in hospital. 80% of participants in the first year of operation were able to return home and the equivalent of 13 acute care bed days were avoided through early discharge from hospital.

**Outreach Services to LTC**
7 nurse practitioners (NP) have been hired to provide outreach services to all 27 LTCHs in our LHIN. NP work with a multidisciplinary team to support LTCHs in managing residents with sudden or semi urgent injuries or illnesses and to facilitate earlier discharge of residents back from hospitals. A complimentary goal is to reduce the need for inappropriate transfers from LTCH to ERs. Early results have been very encouraging with 509 transfers to ER being diverted.

**Peel Halton Acquired Brain Injury Services (PHABIS)**
PHABIS provides outreach services in the community for high need seniors with ABI through a Neuro-behavioural Model of Care, education of and consultation to, the direct care staff and/or family caregiver to support the ability of LTCHs to safely manage their behaviour. Referrals are increasing to this program as they have shown early signs of effectiveness. For example, an ABI patient who spent 2 years at Trillium Health Centre (THC) as an ALC patient has been discharged to a LTCH.

## PRIORITY 1 – IMPROVING ACCESS, QUALITY AND SUSTAINABILITY OF THE HEALTH SYSTEM

### *Goals*

- Reduce ER wait times for treatment and improve patient satisfaction.
- Reduce unnecessary hospital stays.
- Improve access to specialized services across the LHIN.
- Improve the management of patients/clients movement through the system.

### *Objectives*

- Reduce ER treatment wait times by enhancing community capacity to provide non-emergency care.
- Reduce hospital stays by increasing supports in home and community settings.

### *Consistency with Government Priorities*

- As mentioned in the description introduction, this priority directly aligns with the provincial priorities of reducing ER treatment times and reducing ALC days. It is consistent with the ER Strategy which includes reducing the number of visits to emergency rooms and a new Aging at Home Strategy that enables seniors to continue living in their homes.

### *Action Plans/Interventions*

| Action Plans/ Interventions: | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|
| **1. Improve ED Wait Times**<br>a) Lead a quality improvement initiative in partnership with the Ontario Health Quality Council that will see 8 LTC homes in our LHIN participate on a quality improvement collaborative with a focus on falls, pressure ulcers, and ED/Acute care avoidance. | **100%** | | |
| b) Work with hospital partners to continue to seek operational improvements and efficiencies in hospital EDs through targeted quality improvement initiatives - particularly those that have resulted in improvements at other peer hospitals (e.g. THC ED Performance Improvement Program results). | **100%** | | |

| Action Plans/ Interventions: | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|
| c) Implement Pre-Hospital/Diversion communication strategies (e.g. walk-in clinic referrals, Telehealth referral protocols to ER, EMS Catch and Release to SDL/CCAC). | **100%** | | |
| **2. Reduce ALC patient days and improve patient management in hospitals.** | | | |
| a) Implement a Specialized LTCH Behavioural assessment and treatment unit that would support individuals eligible for LTC who have behavioural needs that present a barrier to, or jeopardize living in a LTC setting. | **100%** | | |
| b) Implement a LHIN wide palliative care initiative with an emphasis on home based palliative care thereby reducing hospitalization by 1/3 (from 90 acute beds to 60 beds). | **75%** | **25%** | |
| c) Increase and enhance operation of the Restore program within the LHIN area to further decrease number of ALC patients in hospital and avoidance of premature LTCH placements<br>• Additional location<br>• Enhanced eligibility | **100%** | | |
| d) Implement transitional bed capacity across LHIN. | **100%** | | |
| **3. Continue transformation of community sectors** | | | |
| a) Evaluate impact of SDL in conjunction with the RESTORE program (community sector evaluation of two large programs) with the assistance of ICES. | **50%** | **50%** | |
| b) Continued movement toward a fully integrated and staffed central intake and referral model for all SDL agencies. | **100%** | | |
| c) Evaluate impact of the GSN function. | **100%** | | |
| d) Continued work on re-defining the centralized role and function of the CCAC in the community. | **50%** | **50%** | |
| e) Negotiate new L-SAA agreements with the 27 LTC Homes | **75%** | **25%** | |

## *Expected Impacts of Key Action Items*

- Performance targets are met, including decreasing ER wait times and Alternate Level of Care days (as described in the accountability agreement between the LHIN and the Ministry of Health and Long-Term Care).
- Increased patient satisfaction and quality of care.

## *Risks/barriers to successful implementation*

- Inability of health service providers to recruit staff and ramp up services in a timely fashion.
- Inadequate fiscal resources to address the ED/ALC pressures in the MH LHIN.
- Delayed implementation of the LTCH Act 2007.
- Insufficient nursing and PSWs to support community palliative homecare needs.

## *Mitigating Strategies include:*

- LHIN staff work with hospital staff to identify issues related to data quality and potential quality improvement.
- LHIN strategies working group regularly monitor the wait times performance.

# PRIORITY 2

## CREATE LHIN-WIDE REGIONAL PROGRAMS

### *Description*

In order to improve quality and access to care, the LHIN needs to ensure certain programs are managed consistently across the LHIN. To this end, the LHIN will work with its HSP partners to further develop regional program centres of excellence amongst hospitals, the community sectors and between hospital and community sectors.

Integration of programs and services between sectors will result in better outcomes and provision of more services in an efficient manner. Where critical mass is linked to improved quality of care or improved use of resources, then regional programs that secure these results will be promoted and encouraged.

### *Current Status*

The planning process for clinical integration initiatives is guided by a Clinical Integration Steering Committee with Senior Leadership from the Credit Valley Hospital, Halton Healthcare Services, Trillium Health Centre and the LHIN.

The LHIN has already undertaken a number of integration initiatives that are at various stages of development and implementation. These include:

- Regional initiatives:
    - Antibiotic Stewardship Program.
    - Vascular Program.
    - Neurosurgery Program.
    - Thoracic Program.
    - Chronic Kidney Disease Program.
    - Peritoneal Dialysis Program.
    - Purcutaneous Peripheral Coronary Intervention.
    - Specialized Geriatric Services.
    - Hospital Credentialing for Physicians.
- Shared Scheduling for Hospital Diagnostic Imaging Departments.
- Accreditation Process across Community Support Services and MHA agencies.

However, gaps and uncoordinated service delivery exist in other clinical service areas that require a focus for 2010/11. This includes a high return visit rate of patients with mental health and addictions issues to ER; a lack of coordinated mental health and addictions services for children and youth transitioning to adulthood; a need to better understand the current utilization of complex continuing care and rehabilitation resources to more clearly support the continuum of care; a need to improve coordination and integration of services for maternal, newborn, children and youth; and a need to assess existing palliative care beds within acute care hospital settings. Select activities underway for 2010/11 will include a focus on:

- Complex Continuing Care and Rehabilitation (transitional services);
- Maternal, Newborn, Child and Youth;
- Palliative Care.

## PRIORITY 2 – CREATE LHIN-WIDE REGIONAL PROGRAMS

### *Goals*

- Improve access to and quality of care within key clinical services across the LHIN.
- Maximize capacity across the MH LHIN.
- Improve use of resources to achieve patient care goals.

### *Objectives*

- Develop certain specialized programs that are managed across the LHIN to deliver a LHIN wide consistent quality of service.
- Improve consistency for eligibility to services (i.e. through LHIN wide common assessment and intake tools).
- Regionally standardize access to key regional programs.
- Increase efficiency to deal with growth requirements.

### *Consistency with Government Priorities*

The goals and actions align with a number of Ministry priorities including the government's transformation agenda focused on improving the delivery of health care at the local level and the Maternal Newborn Access to Care Strategy.

### *Action Plans/Interventions*

| Action Plans/ Interventions: | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|
| 1. Develop and implement ALC Strategy recommendation to transform complex continuing care and rehabilitation – Transitional Model. | **50%** | **25%** | **25%** |
| 2. Expand participating providers in the Shared Services West – Purchasing Model. | **50%** | **25%** | **25%** |
| 3. Work in partnership with health service providers to develop and Implement a regional maternal, newborn, child and youth integration program. | **50%** | **25%** | **25%** |
| 4. Work in partnership with health service providers to develop and implement a regional Eating Disorder Program. | **25%** | **25%** | **25%** |

## *Expected Impacts of Key Action Items*

- Reduction in ALC days for medically complex and rehabilitation patients.
- Improved access to complex continuing care and rehabilitation services.
- Increased number of LHIN wide adoption of best practices, common assessment and intake tools.
- Improved efficiency in provision of services.
- Increased quality in patient care.
- Access to specialty programs will be improved and wait times reduced.
- Decreased percentage of emergency department visits for those with mental health and addiction issues that could be managed elsewhere.

## *Risks/barriers to Successful implementation*

- Cultural complacency, resistance or scepticism by health service providers satisfied with status quo or who may feel the proposed change encroaches on territory. Early involvement in the work will help build buy-in to reach goals.
- Lack of alignment or accountability between goals and performance – this will be addressed by putting the right structures in place in the planning stages.
- Overloaded workforce and shortage of resources – this will be addressed through strong leadership.

## *Mitigating Strategies include:*

- Continue to work closely with health service providers to advance improvements in access to services.
- Support development of working teams to advance these initiatives.

# PRIORITY 3

## PREVENTION AND MANAGEMENT OF CHRONIC CONDITIONS

### *Description*

Good management of a chronic disease can help prevent the onset of multiple conditions as people age. This is important for individuals, and also for the health system. As our population gets older, there will be more people with chronic conditions such as diabetes, asthma, heart disease, arthritis, and high blood pressure. This will place significant pressure on local health system resources. We can also expect increased visits to family doctors and ERs. Patients with multiple chronic conditions tend to have longer hospital stays, higher health care costs, increased mortality, and higher hospital readmission rates.

The MH LHIN will work with the MOHLTC to implement the Diabetes Strategy which includes a number of elements such as; increasing access to team based care and expanding chronic kidney disease services.

In 2004/05 the prevalence and incidence rates of diabetes in the MH LHIN were slightly above the provincial average. (Ontario prevalence 8.4; MH LHIN prevalence 8.6; Ontario incidence 8.1; MH LHIN incidence 8.8). By 2006, the number of people with diabetes in the MH LHIN increased 14.3% to 70,749 (ICES). Mississauga (North and South) and Oakville have the highest number of people with diabetes in the MH LHIN.

### *Current Status*

**Diabetes**
Diabetes prevention and management services are provided by multiple health services providers across the continuum including public health, primary care, emergency room care, hospital care, diabetes education programs and pharmacy care.

The MH LHIN has six organizations that currently host Diabetes Education Programs, including one South Asian Outreach team. The MOHLTC provides direct program funding to five (5) of these organizations for diabetes education and care. Credit Valley Hospital Diabetes Care Centre is the largest program in the MH LHIN and has a wait time greater than 5 weeks for Type 2 diabetes education. Credit Valley Hospital funds this program from their global budget and does not receive direct Ministry funding.

Of the six FHTs, only the Credit Valley FHT receives program funding from the Priority Programs Branch of the MOHLTC to provide diabetes education and care to their surrounding community. Three FHTs (Etobicoke FHT, Halton Hills FHT and Prime Care FHT) have a diabetes team (RN RD) funded through their primary care global funding. Summerville and Dorval FHT do not have a Diabetes Education Team but have strong linkages with their local Diabetes Programs. Beginning in the fall of 2009, the Trillium Diabetes Management Centre provided an outreach team to Summerville FHT approximately three days a month.

For 2008/09, the Diabetes Education Programs served approximately 20,842 clients.

Across the MH LHIN, we know that:

- Less than 30% of people with diabetes accessed Diabetes Education Programs in 2008/09; this percentage does not include clients accessing diabetes teams located in FHTs.
- Wait times to access Diabetes Education Programs vary across the LHIN from 2 to 6 weeks for non urgent clients.
- Preliminary data review indicates that one in 10 patients in hospital have diabetes as one of their most responsible diagnoses. Further analysis is required to determine the co-morbidity and how well we are serving this population.
- "Perceived" barriers to Diabetes Education and Care in the MHLHIN include wait times, language barriers, locations, diversity supports. Lack of lifestyle management programs is a perceived need in the community.

In September 2009, the LHIN submitted recommendations to the MOHLTC for expansion of diabetes education teams and received approval for the addition of 2.5 teams to the Trillium Diabetes Management Centre and 0.5 team for the Halton Diabetes Programs.

**Chronic Kidney Disease (CKD)**

There are two regional chronic kidney disease programs in the MH LHIN that provide a comprehensive range of services: Credit Valley Hospital and Halton Healthcare Services. In addition, Trillium Health Centre has seen an increase in the number of inpatient renal cases. The programs are working together under the leadership of Halton Healthcare Services to develop an integrated approach for CKD services in the MH LHIN and will align with the deliverables of the Ontario Renal Network.

We know that:

- By the end of March 2010, it is anticipated that there will be a multi-year implementation plan for the integration of CKD services in the MH LHIN. There will be a need to align this plan with the activities of the Ontario Renal Network (ORN).
- The percentage of home dialysis therapies is 28% in the MH LHIN, which is below the provincial target of 35%.
- There is a lack of LTC Homes across the MH LHIN that provide peritoneal dialysis services. In 2009/10, two LTC Homes received Ministry funding to provide peritoneal dialysis services to their residents. (These are pending MOHLTC approvals).

## *Successes of the Past Year*

1. Developed and implemented a consistent and coordinated approach to educating LTC Home staff re: the management and care of residents with diabetes.
2. Developed and implemented self management workshops for health care professionals across the MH LHIN; over 300 health care providers attended a workshop.
3. Currently disseminating over 500 insulin starter kits across the LHIN.
4. Completed Diabetes Readiness Assessment plan.
5. Developed and began implementing diabetes outreach pilot project to increase referrals to diabetes education programs for clients with diabetes and pre-diabetes.
6. Increased number of LTC Homes that provide Peritoneal Dialysis from 0 to 2; established home therapies program at Burlington Dialysis Satellite and developed a multi-year implementation plan for the integration of CKD services in the MH LHIN.

## PRIORITY 3 – PREVENTION AND MANAGEMENT OF CHRONIC CONDITIONS

### *Goals*

- Improve access to integrated diabetes services.
- Improve access to integrated continuum of Chronic Kidney Disease (CKD) services across the LHIN.
- Enhance the self-management supports for individuals with chronic conditions.

### *Objectives*

- Implement the Ontario Diabetes Strategy.
- Develop and implement an integrated, regional approach to chronic kidney disease.
- Increase awareness of how people with chronic conditions can manage their health and how health care professionals can help them do so.

### *Consistency with Government Priorities*

The above goals and objectives are directly aligned with the province's priority on prevention and management of chronic conditions, specifically the roll out of the Ontario Diabetes Strategy. As well, the creation of a regional integrated model for Chronic Kidney Disease will align with the goals and objectives of the Ontario Renal Network.

### *Action Plans/Interventions*

| Action Plans/ Interventions: | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|
| 1. Continue to implement the Provincial Diabetes Strategy by:<br>• Working with the new Regional Coordinating Centre & Diabetes Network Committee to develop and implement a multi-year plan.<br>• Implementing and evaluating the diabetes outreach pilot project. | **50%**<br><br>**100%** | **25%** | **25%** |
| 2. Continue to work with the Ontario Renal Network to implement provincial chronic kidney disease strategies within the MH LHIN by:<br>• Working with Halton Healthcare Services to implement the multi-year plan to increase access to an integrated, consistent, standardized approach to CKD services across the LHIN.<br>• Implementing strategies to increase home based dialysis therapies in the MH LHIN. | **50%** | **25%** | **25%** |

| Action Plans/ Interventions: | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|
| 3. Improve Self-Management by: Promoting self-management to support health care professionals and individuals with chronic conditions targeting CKD and diabetes service providers. | **25%** | **25%** | **25%** |
| 4. Build community partnerships to support initiatives aimed at prevention and management of chronic conditions by supporting LHIN based initiatives pertaining to the prevention and management of chronic conditions | **25%** | **25%** | **25%** |

## *Expected Impacts of Key Action Items*

- Clients will have increased confidence and success in self-management of their illnesses.
- Increase in # of patients with Diabetes who access integrated diabetes care.
- Increase in the percentage of home-based dialysis therapies.
- Increase in the # of LTC homes that provide peritoneal dialysis services.
- Increase in the # of patients and health care professionals who are using self-management techniques.

## *Risks/barriers to successful implementation*

- Patient and practitioner perceived or actual barriers to diabetes self-management (e.g. knowledge, understanding of illness, awareness of supports available).
- Barriers related to implementing and monitoring evidence-based practice (e.g. data, electronic health records, performance reporting on key indicators back to primary care physicians).
- Lack of primary care engagement.
- Individuals with chronic conditions who do not want to learn about self management.

## *Mitigating Strategies include:*

- Support the development of the Diabetes Regional Coordinating Centre and related network/committee; as well as the work of the Ontario Renal Network to advance chronic disease management across the LHIN.
- Work towards improved access to connectivity (EMR adoption) in the Diabetes Strategy.
- Establish Diabetes Steering Committee with one objective to develop a communication and engagement strategy with primary care.

# PRIORITY 4

## INTEGRATING MENTAL HEALTH AND ADDICTIONS SERVICES

### *Description*

In the MH LHIN, the need for mental health and addictions services is increasing. We know there are increasing numbers of people with mental health and addiction issues returning to our hospital emergency departments. People with mental health and addiction challenges often have long wait times for assessment and services. Addressing gaps in services and wait times can reduce the number of non-urgent cases treated by emergency departments.

This priority addresses the challenges facing people living with mental illness and/or addictions and their families in accessing a fragmented system, through a multi-faceted approach to promote service integration. This fragmentation is exacerbated for transitional aged youth (16-24 years) changing from children and youth to adult services.

### *Current Status*

**Scope of services currently provided:**
Services include a range of hospital, ambulatory and community based mental health and addiction services, including crisis response, inpatient and residential treatment, assertive community treatment, case management, counselling and treatment, peer support and day programming.

**Number of providers providing service:**

- 7 community programs offering mental health services, including 2 supportive housing agencies.
- 3 agencies provide treatment services for drug, alcohol and problem gambling, including a residential treatment program.
- 106 inpatient mental health beds across our three hospital corporations with 3 psychiatric out-patient medical services.
- 73 psychiatrists practicing in MH LHIN.
- 83 case managers provide a range of both mental health and addiction services.

**Number and type of clients serviced annually:**
In 2008/09, the MH LHIN hospitals admitted 2,500 patients suffering with addictions and/or a mental illness. These individuals were either a threat to themselves, unable to care for themselves, or were experiencing a psychiatric symptom. From a weighted case perspective, mental health and addictions experienced a 37% increase from 2006/07 to 2008/09.

Yearly hospital and MH LHIN data indicate that the largest diagnosis category for MH&A visits to the ED is substance abuse (27.3%), primarily alcohol abuse; both depression and anxiety each account for 24% of ED visits. From an ALC perspective, there was a 60% increase in ALC patient days attributed to patients with a mental health and addiction from 2006/07 to 2008/09.

In 2008/09, 23% of patients (3,645 visits) presenting at the ED (16,119 visits) required admission. In addition 32% of people seeking mental health or addiction services at our Emergency Departments are between the age of 19 and 34.

**Key issues facing this client group:**

1. Complex clinical presentation, particularly in the area of concurrent disorders and dual diagnosis. Approximately 50% of people diagnosed with a mental disorder, also have a substance abuse problem. Evidence suggests a majority of clients that access addiction treatment also have an underlying mental health concern, and that treating both of these conditions concurrently rather than separately is associated with improved outcomes in both areas (Health Canada, Best Practices: Concurrent Mental Health and Substance Use Disorders, 2002). These are the concurrent disorders clients.

2. People living with a serious mental illness are at a higher risk of experiencing a wide range of chronic physical conditions, such as diabetes.

3. Access to services - Clients and families report difficulty securing mental health and addiction services. Several factors contribute to this:
   - Stigma associated with mental illness and addictions. Stigma and discrimination create barriers to one's recovery.
   - Lack of information on available services. They report difficulty in finding information on what services are available, and due to stigma, may be reluctant to ask the usual source of such information, friends and neighbours. This is especially true for individuals with concurrent disorders or dual diagnoses.
   - Mental Health and Addiction services are not visible in our communities with services located in low rental units in industrial parts of town where there is poor access to public transit.

4. Lack of integration with Primary care, a key access point to the MH&A system. In addition, there is a shortage of community psychiatrists within the MH LHIN. Individuals suffering with an addiction or mental illness typically seek help when they are in crisis or distress for the majority of cases; they seek help at an Emergency Dept. The ED data shows that MH LHIN is the only LHIN in Ontario showing an increase in repeat visits to ED within 30 days, over the past 3 years, 2006/07 to 2008/09 - 8% to 12%.

## *Successes of the past year:*

- Regional inpatient psychiatry unit for children and adolescents created at Halton Healthcare Services' Oakville-Trafalgar Memorial Hospital for all Mississauga Halton LHIN residents.
- A consortium of MH & A providers, the MH LHIN and consumers implemented a number of initiatives:
  - Designed a new client satisfaction measurement tool which was implemented by all community based mental health and addiction funded programs.
  - Facilitated an evaluation of existing partnerships in order to determine what factors contribute to the success of the partnership and identified opportunities to strengthen integration.
  - A resource brochure titled 'Mental Health and Addiction Services, Mississauga Halton LHIN' was developed and mailed to all family physicians across LHIN 6.
- Built a sustainable education program with education events open to all HSPs on a quarterly basis.

- HSPs contracted for project management service to establish 3 co-location sites for MH&A and other support services, to integrate services under one roof.
- Established a Transitional Aged Youth Task Team to create a seamless transition for youth leaving Youth Sector and moving into the Adult Sector.

## PRIORITY 4 – INTEGRATING MENTAL HEALTH AND ADDICTIONS SERVICES

### *Goals*

- Improve:
  - Access to mental health and addictions services.
  - Community mental health supports to reduce ER visits and hospital stays.
  - Access to early diagnosis and treatment.

### *Objectives*

- Create multi-service centres (for example, health and social services under one roof).
- Implement a common intake and assessment tool for all LHIN funded mental health and addictions services to use.
- Increase community capacity and supports to reduce ER visits.
- Partner and work with other ministries and jurisdictions on education and support programs.

### *Consistency with Government Priorities*

With the priority to promote integration and improve access to mental health and addiction services, the MH LHIN is in alignment with provincial strategies. Specifically, these goals and objectives directly support the government's Mental Health and Addictions Strategy. Our objectives will also positively influence the priority on ER Service Improvement by diverting visits to the ER as individuals will obtain services in the community.

### *Action Plans/Interventions*

| Action Plans/ Interventions: | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|
| 1. Implement community supports for concurrent disorders (crisis response in ED). | **100%** | | |
| 2. Support integration of community mental health and addictions with social services through a co-location initiative. | **25%** | **25%** | **50%** |
| 3. Implement standardized assessment, screening, and intake tools that will assess clients for both mental health and addictions. | **100%** | | |

## *Expected Impacts of Key Action Items*

- Increased access to multiple and co-located mental health and addictions services and improved service coordination.
- Opportunities for realignment and integration will be identified.
- Decreased ER repeat visits for mental health and addictions clients.
- Access to mental health and addiction services will be improved.
- Increased early identification of mental health and addictions clients.

## *Risks/barriers to successful implementation*

- Accessing and navigating Mental Health and Addiction services is a challenge due to lack of alignment and service integration.

## *Mitigating Strategies include:*

- Gaps in service will be identified and opportunities for realignment.

# PRIORITY 5

## ENHANCING SENIOR'S HEALTH, WELLNESS AND QUALITY OF LIFE

### *Description*

Age is the greatest predictor of increased prevalence of illness and consequently, the utilization of health care services. As the population ages, this will further strain a local health system that is already pressured to meet the complex needs of a diverse seniors population.

In next 25 years, the number of adults 65+ will increase 170% from 110,000 to 290,000 (Census 2006). By 2031, the 65+ age group will represent approximately one fifth of total MH LHIN population. In addition, the MH LHIN is home to 50,320 adults over the age of 75 and is the second fastest growing LHIN regions in the province for this age group. By 2031, the number of adults 75 and older will increase by 156% to 128,823.

Seniors are also heavy users of acute hospital services. Based on a recent analysis of individuals age 75 and older, the main source of entry into the hospital system is through the ED, and ED visits to hospital are increasing. Furthermore, patients aged 75+ would most likely be designated alternate level of care (ALC) for a part of their hospital stay. For the top twenty diagnoses (ICD10 codes) there is a strong correlation between the 75+ patients and ALC stay, with the 75+ patients accounting for more than 85%.

Furthermore, the current system of services for seniors is fragmented and difficult for consumers and families to navigate. The system consists of a collection of organizations each with their own mandates, philosophies, eligibility criteria, assessment tools and service delivery approaches. Opportunities to improve access and service delivery through enhanced integration, coordination, communication and client-focused care have been identified by both consumers and service providers.

### *Current Status*

There are a range of programs and services that are available to seniors. These include:

- 27 long-term care homes with 4,156 beds.
- 34 community support services agencies providing an array of services to assist individuals who need help to function independently because of a disability, illness or limitation due to aging including 12 adult day programs, 12 Supports for Daily Living programs.
- 12 mental health and addictions programs.
- 1 community care access centre which providers a range of in-home services and specialized programs, information and referral, and placement into long-term care homes.
- 3 hospitals corporations on 6 sites including 286 complex continuing care beds.
- 7.0 FRCPC Geriatricians - none working full-time in geriatrics.

In addition, over the past two years, the MH LHIN has invested $19.1 million in expanding community support services for seniors. These programs build on the LHIN's many existing programs which currently provide high quality care to our seniors and include:

- Implemented Transitional Capacity. For example:
    - Created capacity to address alternate level of care pressures (e.g. transitional bed capacity).

- Increased community capacity as alternative to Long Term Care Homes to directly impact on referrals from ERs and post acute care. For example:
    - Increased supports for daily living (24/7 personal support in seniors homes).
    - Improved transitions for seniors from hospital to their homes (e.g. Wait at Home, Stay at Home; Restore Program).
    - Created urgent geriatric assessment clinics and enhanced geriatric outreach.

- Increased CCAC, LTC Homes and Community sectors to manage frailer and 'high' need seniors and reduce reliance on ER. For example:
    - Enhanced supports for seniors and families affected by serious mental illness and/or behavioural difficulties.
    - Expanded support for residents of long-term care homes through Nurse Practitioners.
    - Enhanced palliative care services.
    - Enhanced acquired brain injury services.

- Focused on diversion and prevention initiatives for 75+ seniors – largest driver of intensity of care in ERs and constitute the majority of ALCs in hospital. For example:
    - Increased adult day programs.
    - Expanded health promotion and wellness initiatives (falls prevention and chronic disease prevention and management).
    - Increased transportation services to help seniors get to medical and wellness appointments.
    - Increased intensive navigation for seniors 75+ who visit the ER and are treated and released.
    - Enhanced elder abuse support services.
    - Enhanced telephone re-assurance.
    - Increased home help, and home maintenance and repair services.

These services help seniors to live at home for as long as possible and improve their quality of life. They have also created efficiencies in the system of care for seniors and fostered many collaborative initiatives. Furthermore, these services have helped to reduce both ER wait times and the number of Alternative Level of Care days.

**Key issues facing this client group**

- Specialized Geriatric Services (SGS) currently available in the LHIN are fragmented and under-resourced to meet the needs of the growing 75+ population. Access to SGS is not equitable across the LHIN and is often hindered by hospital catchment area and lengthy waiting list of 6+ months.
- Every 10 minutes in Ontario, at least one senior visits an emergency department after a fall and every 30 minutes in Ontario, at least one senior is admitted to hospital after a fall. Forty percent of admissions to LTC beds are fall-related.
- Respite services were identified as a need through the community engagement activities (Summer 2008) with seniors and their caregivers / families. Provision of respite services

has been shown to prevent caregiver burnout / deterioration of health and prolong their ability to care for their loved one, consequently preventing premature institutionalization and increasing the ability of seniors to remain at home for as long as possible.

- Ontario seniors 75+ account for 4.4% of the population but they account for 19% of discharges from hospital in 2006. Additionally, when seniors are admitted to hospital they stay longer and require more resources. Seniors account for 37% of total length of stay in hospitals within Mississauga Halton. The average length of time that seniors spend in hospital increases significantly by age. In 2006, the average length of stay (ALOS) for the Mississauga Halton population as a whole was 5.1 days. For seniors aged 65 to 69, the ALOS was 7.5 days. For seniors aged 75+ the ALOS was 9.9 days. Furthermore the ALC ALOS has been increasing for seniors aged 75+. In 2005, the ALC ALOS was 12 days, in 2006 13 days and in 2007 17 days.
- As our population gets older, there will be more people with chronic conditions such as diabetes, asthma, heart disease, arthritis, and high blood pressure. With this come increased visits to family doctors and ERs. If not well managed, one chronic disease can lead to multiple conditions as people age. Patients with multiple chronic conditions tend to have longer hospital stays, higher health care costs, increased mortality, and higher hospital readmission rates.
- Seniors and their caregivers are not fully informed and knowledgeable about the services available to them and/or how to access them. Our community engagement sessions have found that seniors are frustrated with having to navigate their way through the health care system and would like an easier method of doing so.

## *Successes of the past year*

- Implemented and monitored Aging at Home (AAH) initiatives.
- Developed a Regional Specialized Geriatric Services Strategy.
- Created 5 urgent geriatric assessment clinics and expanded geriatric outreach.
- Created a Falls Prevention Clinic at Halton Healthcare Services Corporation and Trillium Health Centre.
- Expanded Home Support Exercise Program to Adult Day Programs and Supports for Daily Living settings.
- Identified needs / gaps for respite services in the community, and determined the immediate respite capacity required and the best approach to delivery of respite services.
- Expanded in-home respite services.
- Developed common intake/referral form including risk screening tool; common user friendly service definitions; common phone answering/transfer protocols; and, performance measurement plan.
- Tested the common tools and processes, and measured and evaluated results.
- Developed a LHIN-wide approach to palliative care.

## PRIORITY 5 – ENHANCING SENIOR'S HEALTH, WELLNESS AND QUALITY OF LIFE

### *Goals*

2. Achieve the best combination of home and community services for "at risk" seniors.
3. Improve access to and coordination of services for seniors.
4. Support seniors in managing their own health, wellness and quality of life.

### *Objectives*

- Transform community capacity and programs to help "at risk" seniors live at home as long as possible.
- Determine future needs for long-term care home beds and services.
- Implement specialized geriatric services.
- Work with organizations that lead in prevention and wellness services (health care agencies, disease associations, and the broader community services sector).

### *Consistency with Government Priorities:*

In alignment with the MOHLTC's priorities, the MH LHIN is focused on reducing ALC and inappropriate use of ED by seniors with an emphasis on:

- Elderly at risk:
    - Of experiencing a medical crisis and ending up in the ED.
    - Lingering in hospital awaiting a more suitable place (ALC patient days), or are prematurely admitted to a LTC home because of insufficient community supports.
- Diverse elderly client groups:
    - Consideration of services to meet client's cultural and linguistic needs, and specific disease requirements.
- Healthy seniors:
    - Supportive measures designed to prevent deterioration into crisis and/or institutionalization.

Over the past three years, our LHIN has invested $33,733,872 in expanding community support services for seniors. These services help seniors to live at home for as long as possible and improve their quality of life. This has created efficiencies in the system of care for seniors and has fostered many collaborative initiatives. It has also helped to reduce both ER wait times and the number of Alternative Level of Care days, both of which are key government priorities.

## *Action Plans/Interventions*

| Action Plans/ Interventions: | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|
| 1. Implement funding recommendations for year 3 Aging at Home investment that will continue to increase community capacity. | **100%** | | |
| 2. Implement components of the specialized geriatrics services strategy. | **25%** | **25%** | **50%** |
| 3. Implement common tools and processes for intake and referral associated with the ASSIST model. | **50%** | **50%** | |
| 4. Evaluate new in-home respite services. | **100%** | | |
| 5. Identify future capacity needs for Long Term Care Home Beds and Services. | **25%** | **25%** | **25%** |
| 6. Develop and implement a communication strategy regarding programs and services available in the MH LHIN. | **100%** | | |

## *Expected Impacts of Key Action Items*

- Increased supports and services for “at risk” seniors in their homes and communities to reduce ER visits.
- Increased timely access to specialized geriatric assessment and consultation services.
- Decreased percentage of seniors 75 years of age and older living in institutional settings.
- Increased availability of appropriate long-term care beds and services.

## *Risks/barriers to successful implementation*

- Availability of:
    - Transportation support to attend programs or appointments.
    - Culturally sensitive services to seniors.
    - Health human resources and capital to continue to expand community capacity.
    - Information systems and technology to facilitate a seamless continuum of care.
- Aging population with decreasing number of available caregivers (informal and health human resource issues).

## *Mitigating Strategies include:*

- Continue to work with partners (within and beyond the health care sector) to improve access to and transition between services for seniors.

# PRIORITY 6

## STRENGTHENING PRIMARY HEALTH CARE

### *Description*

When residents in the MH LHIN need health care, they most often turn to primary health care services. Visits to family physicians, consultations with nurse practitioners, telephone calls to health information lines, and advice received from pharmacists are just some examples of primary health care services. Primary health care is key to maintaining and improving our health, and to the quality and sustainability of our local health care system

Reducing wait times, with a special focus on emergency departments, and quality family health care for all Ontarians is a priority of the government. It's important that citizens of the MH LHIN have access to primary health care around the clock which should help to relieve reliance on hospital emergency departments for non-emergency care.

The MH LHIN will work with our primary health care providers to address our priority of transforming and integrating programs and services to improve overall performance in the local health care system. Additionally, we will work with our family physicians:

- To facilitate the increase of family physicians' use of electronic medical records. This will ultimately lead to improved patient care, safety and access to important clinical health information.
- In diabetes management – where primary care is critical to effective patient management.
- In providing continuity of care to mental health & addictions clients.
- To advance our palliative care initiative across the LHIN.

### *Current Status*

- Difficulty in gaining access to primary care physician services is experienced by 6.9% (61,000) residents of MH LHIN.*
- There are 822 physicians (1 physician per 1,344 people) in MH LHIN providing family medicine, of which 264 are considered solo practitioners not involved in a group network or association (e.g. comprehensive care model). 83 physicians are involved with one of the six family health teams in MH LHIN. The MH LHIN contains one satellite community health centre whose main office is located in Toronto Central LHIN.**
- The MH LHIN supports the team of seven Nurse Practitioners providing additional care and support to complex residents in all 27 Long Term Care Homes.
- The current physician EMR adoption rate for the MH LHIN is one of the lowest at 16%.

***Primary Care Access Survey, April 2008 to March 2009, Prepared by the Health Analytics Branch, MOHLTC, November 24, 2009.*

***MOHLTC, Ontario Physicians Human Resource Data Centre, Active Physician Registry, December 31, 2008, Report Prepared October 8, 2009*

## PRIORITY 6 – STRENGTHENING PRIMARY HEALTH CARE

### *Goals*

- Improve access to family health care.
- Increase family physicians' use of electronic medical records.

### *Objectives*

- Increase capacity for family health care throughout the LHIN.
- In partnership with Health*Force*Ontario, increase the number of physicians in the LHIN.
- Help make it quick and efficient for family physicians to start using electronic medical records.

### *Consistency with Government Priorities*

Regular and timely access to primary health care establishes a relationship of trust and accountability between the patient and health care provider which promotes continuity of care for those with chronic conditions. For those who do not have a chronic condition, access to primary care provides a range of care options when an acute illness occurs that does not necessarily include a visit to the hospital. Strengthening our primary health care sector supports many government priorities including our ability to reduce ER wait times and improve the population health of people with diabetes.

Also, increasing the rate of EMR adoption will promote information flow between and within health care providers reducing the amount of duplication that currently takes place. As well, real time access to information can facilitate quicker decisions to take place with respect to service delivery thus improving patient transition out of the hospital for when their acute care episode is completed.

### *Action Plans/Interventions*

| Action Plans/ Interventions: | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|
| 1. Establish a Primary Health Care Steering Committee. | **100%** | | |
| 2. Develop and implement a primary health care engagement strategy. | **50%** | **25%** | **25%** |
| 3. Continue to implement Nurse Practitioner led clinics and Family Health Teams into LHIN when government announces investment opportunities. | **100%** | **100%** | **100%** |
| 4. Continue to pursue the development and implementation of the eHealth initiative. | **See eHealth Priority 7** | | |

## *Expected Impacts of Key Action Items*

- Increased number of practitioners delivering family health care.
- Increased number of practitioners consulting and supporting family health care practitioners.
- Increased number of complex and vulnerable patients who have providers that provide family health care.
- Increased number of physicians implementing the use of electronic medical records.

## *Risks/barriers to successful implementation*

- Capacity of Ontario MD to support the number of interested family physicians with EMR implementation.
- Available funding to support EMR adoption rates especially for physicians who would like to upgrade to preferred vendors and platforms.
- Availability of family physicians to be recruited into the MH LHIN.
- The ability of family physicians to link up with specialty care (i.e. both specialists and program based services like Diabetic Education, Addictions, counselling).
- Ability of family physicians to provide after hours care.
- Limited access to new investments for Family Health Teams or Nurse Practitioner.

## *Mitigating Strategies include:*

- Continue to work in unison with provincial initiatives such as HealthForceOntario.

# eHEALTH

## *Description*

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

- Diabetes Management.
- Medication Management.
- Wait Times.
- Foundational Priorities.
    - Clinical and Operational Initiatives.
    - Enabling Initiatives.
    - Technology Platform Initiatives.

## *Current Status*

- In 2009/10, the MH LHIN updated its eHealth Strategy to better align with the provincial strategy. The LHIN created a governance model to oversee the execution of the strategy and a tactical plan to support planning.
- The MH LHIN has created a Project Management Office (PMO) to identify and oversee opportunities for implementing technology and information management initiatives. The LHIN also initiated a LHIN Privacy Committee.
- The LHIN has conducted a number of initiatives to support the strategy including:
    - Developed Physician eHealth Strategy and initiated Physician eHealth Steering Committee.
    - Conducted a Diabetes Readiness Assessment and developed a supporting Diabetes Readiness Plan.
    - Collaborated with 6 other LHINs on Resource Matching and Referral Current State Assessment project.
    - Managed OLIS-EMR Integration Pilot Project with eHealth Ontario and Summerville FHT.
    - Introduced new Community Sector Provider Portal for community services and mental health and addictions providers.
    - Submitted 14 funding proposals to eHealth Ontario for regional eHealth priorities.

## *Goals*

MH LHIN's Strategic goals for eHealth are grouped within 3 Strategic Directions:

| Strategic Direction | Strategic Goals |
|---|---|
| 1. Improve LHIN wide information integration to enable the health service providers in the LHIN to achieve the goals set out in the IHSP. | ▪ Facilitate delivery of strategic eHealth projects, on schedule, within budget and with an appropriate level of quality.<br>▪ Ensure that all eHealth projects within the LHIN are governed and coordinated.<br>▪ Strategically align HSPs and LHIN objectives.<br>▪ Develop standards and promote collaboration between stakeholders.<br>▪ Provide a framework for the management of information.<br>▪ Ensure Regional Programs are efficient and effective.<br>▪ Establish and maintain appropriate information sharing policies and practices for MH LHIN healthcare providers. |
| 2. Align LHIN eHealth initiatives with the Provincial eHealth direction as set out in the Ontario eHealth Strategy to improve patient care, safety and access. | ▪ Manage diabetes using best practices.<br>▪ Allow for access of the Drug Profile Viewer beyond the ER.<br>▪ Improve patient referrals and divert unnecessary ER visits.<br>▪ Enable the sharing of lab results.<br>▪ Improve the exchange of information between providers.<br>▪ Improve patients' ability to self-manage care.<br>▪ Broaden and accelerate physician EMR participation.<br>▪ Establish common repositories for DI information sharing.<br>▪ Ensure alignment of CCIM systems and the provincial strategy.<br>▪ Prepare for implementation of GTA HIAL. |
| 3. Leverage the assets currently existing in the LHIN to build capacity within the community and optimize investments. | ▪ Ensure all organizations have the base level of IT infrastructure and support required to participate. in the eHealth strategy.<br>▪ Improve information sharing exchange across the continuum of care.<br>▪ Leverage coordinated logistics, purchasing, contract management and equipment to provide the best value, improve quality of service and facilitate the reallocation of resources to direct patient care. |

## *Consistency with Government Priorities*

MH LHIN will continue to align our eHealth initiatives with the government priorities set out in Ontario's eHealth Strategy.

## *Action Plans/Interventions*

| Action Plans/ Interventions: | | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|---|
| 1 | **Diabetes Management Area** | | | |
| *1.1 | Diabetes Registry Implementation | 25% | 25% | 25% |
| *1.2 | Diabetes Strategy Implementation (BDDI) | 25% | 25% | 25% |
| 2 | **Medication Management Area** | | | |
| *2.1 | Medication Management DIS (incl. ePrescribing) | 25% | 25% | 25% |
| *2.2 | Medication Management DPV | 25% | 25% | 25% |
| 3 | **Wait Times Area** | | | |
| *3.1 | Wait Times eReferral - Resource Matching & Referral | 25% | 25% | 25% |
| *3.2 | Wait Times eReferral - ED CCAC Notification | 50% | 50% | |
| *3.3 | Wait Times - WTIS | 25% | 25% | 25% |
| *3.4 | Wait Times - EDRS | 25% | 25% | 25% |
| *3.5 | Critical Care Information System - CCIS | 25% | 25% | 25% |
| *3.6 | Surgical Efficiency Target Program - SETP | 25% | 25% | 25% |
| 4 | **Clinical Strategy & OPS. Area** | | | |
| *4.1 | Connecting GTA HIAL<br>4.1.1 Ontario Lab Info System - OLIS<br>4.1.2 Provider Portal | 25% | 25% | 25% |
| *4.2 | Physician eHealth - EMR | 25% | 25% | 25% |
| *4.3 | DI/PACS | 25% | 25% | 25% |
| *4.4 | CCIM - i.e. CHRIS (CCACs), MIS (CSS) | 25% | 25% | 25% |
| *4.5 | Patient Portal - part of Diabetes rollout | 25% | 25% | 25% |
| 5 | **Enabling Capabilities Area** | | | |
| 5.1 | Regional Privacy Model | 30% | 35% | 35% |
| 5.2 | MH LHIN eH Office & PMO | 75% | 25% | |
| 5.3 | Shared Services West Increased Utilization | 25% | 25% | 25% |
| 5.4 | LHIN IM Framework & Sustain | 75% | 25% | |
| 6 | **Technology Platform & Services** | | | |
| 6.1 | Infrastructure for Initiatives | 25% | 25% | 25% |
| 6.2 | LHIN IS/IT Infrastructure Blueprint & Sustain | 75% | 25% | |
| 6.3 | LHIN IS/IT Shared Services - Feasibility, Model, Imp., Ops. | 25% | 50% | 25% |
| 6.4 | LHIN Regional Programs | 25% | 25% | 25% |
| 7 | **Watch List** (no %'s because this is a watch list) | | | |
| 7.1 | Telemedicine | | | |
| 7.2 | Panorama | | | |
| 7.3 | Remote Access | | | |
| 7.4 | Consumer eHealth | | | |
| 7.5 | CDPM/Colon Cancer Check | | | |
| 7.6 | eCHN | | | |
| 7.7 | CPOE | | | |

## *Expected Impacts of Key Action Items*

- Improved sharing and access to information across LHIN health care providers.
- Improved transition for patients from acute to community care, long term care, rehab and complex continuing care.
- Improve appropriate use of hospital and community based resources by providing better discharge options and support for ED and ALC patients.
- Improved access to integrated diabetes services.
- Improved ability to drive results through information and transparency of reporting.
- Improved ability to meet performance standards and hold each other accountable.
    - Optimized IT/IS/IM investments by organizing and leveraging existing assets.

## *Risks/barriers to successful implementation*

- Funding and support from eHealth Ontario, OntarioMD, Cancer Care Ontario, Community Care Information Management (CCIM) and other provincial organizations contributing to solutions identified in Ontario's eHealth Strategy.
- Collaboration of HSPs within MH LHIN and with other LHINs.
- Alignment of HSP plans and resource availability/contribution as required from LHIN HSPs.

## *Mitigating Strategies include:*

- Significant upfront work has been done through the development of the PMO office and tactical plans.

# FRENCH LANGUAGE SERVICES

## *Description*

The Francophone population in the MH LHIN LHIN consists of 16, 655 residents (1.7%) whose mother tongue is French.

## *Current Status*

- MH LHIN staff have quarterly meetings with the local Francophone Leaders of Centré de services de santé, Peel et Halton (CSSHP) for broad consultation and input to identified local needs, health system planning, and human resources availability.
- The MH LHIN continues to work with the 5 LHINs on a GTA Toronto Region French Language Health Services Planning and Support Committee and will in collaboration with the GTA LHINS complete a federal proposal on FLHS needs for the GTA area.
- As part of the IHSP refresh process, the LHIN conducted focused community engagement events with the Francophone community.
- MH LHIN staff conducted a survey with all Health Service Providers to determine French-speaking health human resource capacity, available services and programs delivered in French as well as policy and procedures in place regarding FLS. We had a 78% response rate. The MH LHIN are reviewing the results to determine gaps and future opportunities in FLHS.
- LHIN staff met with the five Health Service Providers (HSP) that are ‘identified’ under the French Language Services Act (FLSA) to provide services in French to inform them of the Local Health Services Integration Act (LHSIA) and the FLSA and their role and responsibilities in implementation of FLS. The LHIN reviewed the requirements to complete the HSP French Language Services Implementation Plan.

## FRENCH LANGUAGE SERVICES

### *Goal*

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

### *Action Plans/Interventions*

| Action Plans/ Interventions: | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|
| 1. Work with the MOHLTC to further the Ministry initiatives relating to French Language Health Services including input and actions related to the new Francophone Community Engagement Regulation. | **25%** | **25%** | **25%** |
| 2. Work with the Provincial coordinator to develop FLHS operational and accountability framework. | **100%** | | |
| 3. Work with the Francophone Community to develop a Francophone healthcare needs assessment. | **100%** | | |
| 4. Develop a MH LHIN French Language Health Service Indicator Tool for assessing local Francophone population needs, gaps in service, health system planning, a communication plan, an integration plan, and educational Francophone workshops, and an evaluation process. | **100%** | | |

### *Expected Impacts of Key Action Items*

- Coordination with the MOHLTC will foster congruence of planning activities for French language services with provincial strategies and priorities including a FLS operational and accountability framework.
- Improving coordination among the sectors and individual providers.
- Increased knowledge of Francophone community in health prevention and promotion through workshops on identified health needs.
- A MH LHIN FLHS Indicator Tool to guide the working of the LHIN to meet the Francophone community needs.

### *Risks/barriers to successful implementation*

- Failure to effectively engage the Francophone community could impair the LHIN's ability to meet the goals set out in the IHSP regarding ensuring French language services.

### *Mitigating Strategies includes:*

- Ongoing engagement with key identified stakeholders.

# ENGAGEMENT WITH ABORIGINAL PEOPLE

## *Description*

There are approximately 4,400 identified aboriginals within the MH LHIN representing about 0.4% of the population. The aboriginal community acknowledges that census statistics under-report the true number of Métis, First Nations, and Inuit residents living in a community as some aboriginal individuals do not want to be identified or do not see the value of participating in a census. However, members of the aboriginal community seek health and social services through main stream providers or travel to Toronto to seek culturally sensitive services through Anishnawbe Health - the only Aboriginal health centre in the Greater Toronto Area (excluding Hamilton).

## *Current Status*

- The MH LHIN continues its commitment to exploring opportunities for community engagement with Aboriginal people by meeting with Aboriginal leaders, community members, and health service providers. Specifically, representation from the Credit River Métis Council, the Peel Aboriginal Network, and the Métis Nation of Ontario are collaborating with the MH LHIN and the Central West LHIN to complete a comprehensive needs assessment and priorities report. The purpose of this work is to collect current views and information on the health status and health service needs of the Aboriginal people within the CW and MH LHINs. The study is set to commence in the winter of 2010 with a community forum targeted in the spring of 2010 for presenting the findings to the aboriginal community and other interested stakeholders.
- For MH, funding for this initiative is through a funding grant received by The Aboriginal Health Transition Fund in association with a joint application submitted by the MH LHIN, Hamilton Niagara Haldimand Brant LHIN and the Waterloo Wellington LHIN.
- Aboriginal health planning is complex and needs to consider the various community and groups as well as the variation in issues and approaches that exist among these groups.

## ENGAGEMENT WITH ABORIGINAL PEOPLE

### *Goal*

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

### *Action Plans/Interventions*

| Action Plans/ Interventions: | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|
| 1. Develop an engagement plan to support a collaborative relationship with Aboriginal people. | **100%** | | |
| 2. Work with the Region of Peel's Aboriginal Steering Committee to participate in joint community events to promote common goals of engagement. | **100%** | | |
| 3. Together with the five GTA LHINs, create a common aboriginal planning entity to address the LHIN responsibilities delineated in the provincial regulations for Aboriginal community engagement. | **50%** | **50%** | |

### *Expected Impacts of Key Action Items*

- Improved sharing of information among providers will support service coordination.
- Educational opportunities for the aboriginal community and for health service providers will be increased.
- Key priorities will be identified by working with the CW LHIN, the MOHLTC, Health Canada partners and service providers.
- Relationships will be fostered and strengthened for ongoing communication and collaboration.

### *Risks/barriers to successful implementation*

- Lack of quality population and health data.
- Jurisdictional issues regarding the delivery of health care services.
- Limited knowledge by the LHIN of program directions and resource investments by Health Canada and other Ministries regarding the Aboriginal communities.
- Lack of culturally sensitive, linguistically accessible services.

### *Mitigating Strategies includes:*

- MH LHIN staff continues to work with and engage Aboriginal people in developing its community engagement plans.
- MH LHIN continues to meet with other Ministries to gather information regarding Aboriginal policies, programs, and services.

# PLANNING FOR LHIN OPERATIONS

The following documents set the context for operational planning and resource allocation:

- The MOHLTC 10 year strategic plans.
- The Ministry LHIN Accountability Agreement.
- The MH LHIN Integrated Health Service Plan and Strategic Priorities.

## *Current Status*

For 2009/10, significant resources have been allocated to the following priority initiatives:

- IHSP Community Engagement;
- Emergency Room (ER)/Alternate Level of Care (ALC);
- Wait Times;
- Achieving signed Hospital and LTC Service Accountability Agreements;
- Aging at Home Strategy and initiatives.

# BUDGET

| Operations Spending Plan | | | | | |
|---|---|---|---|---|---|
| **LHIN Operations ($)** | **2008/09 Actuals** | **2009/10 Forecast** | **2010/11 Plan** | **2011/12 Plan** | **2012/13 Plan** |
| **Operating Funding (excluding initiatives)** | **4,018,491** | **4,184,601** | **TBD** | **TBD** | **TBD** |
| **Initiatives Funding (e.g. E-Health, A@H, ED, Wait Time, etc.)** | **538,300** | **805,000** | **5,000** | **5,000** | **TBD** |
| **Salaries and Wages** | 2,128,669 | 2,382,043 | 2,537,243 | 2,613,361 | 2,691,761 |
| **Employee Benefits** | | | | | |
| HOOPP | 201,268 | 237,650 | 254,000 | 261,600 | 269,400 |
| Other Benefits | 302,315 | 264,469 | 282,000 | 290,500 | 299,200 |
| ***Total Employee Benefits*** | ***503,583*** | ***502,119*** | ***536,000*** | ***552,100*** | ***568,600*** |
| **Transportation and Communication** | | | | | |
| Staff Travel | 24,462 | 27,600 | 28,400 | 29,250 | 30,100 |
| Governance Travel | | 15,000 | 15,500 | 16,000 | 16,500 |
| Communications | 58,845 | 48,000 | 49,400 | 50,800 | 52,300 |
| Others | | | | | |
| ***Total Transportation and Communication*** | ***83,307*** | ***90,600*** | ***93,300*** | ***96,050*** | ***98,900*** |
| **Services** | | | | | |
| Accommodation | 252,513 | 215,489 | 245,400 | 252,762 | 260,300 |
| Community Engagement | 143,652 | | | | |
| Consulting Fees | 56,820 | 168,850 | 199,700 | 205,700 | 211,900 |
| Governance Per Diems | 171,175 | 175,000 | 180,250 | 185,700 | 191,300 |
| LSSO Shared Costs | 300,000 | 330,000 | 350,000 | 350,000 | 350,000 |
| LINC | | 50,000 | 50,000 | 50,000 | 50,000 |
| Other Meeting Expenses | 11,006 | 45,000 | 46,350 | 47,700 | 49,000 |
| Other Governance Costs | 54,355 | 60,000 | 61,800 | 63,700 | 65,600 |
| Staff Development | | 40,000 | 41,200 | 42,436 | 43,700 |
| Other Services | 267,591 | 64,500 | 66,400 | 68,400 | 70,500 |
| ***Total Services*** | ***1,257,112*** | ***1,148,839*** | ***1,241,100*** | ***1,266,398*** | ***1,292,300*** |
| **Supplies and Equipment** | | | | | |
| IT Equipment | | 6,000 | 6,180 | 6,400 | 46,400 |
| Office Supplies & Purchased Equipment | 39,577 | 55,000 | 56,650 | 58,300 | 60,000 |
| Other S & E | | | | | |
| ***Total Supplies and Equipment*** | ***39,577*** | ***61,000*** | ***62,830*** | ***64,700*** | ***106,400*** |
| Capital Expenditures | | | | | |
| **LHIN Operations: Total Planned Expense** | **4,012,248** | **4,184,601** | **4,470,473** | **4,592,609** | **4,757,961** |
| **Annual Funding Target** | | 4,989,601 | #VALUE! | #VALUE! | #VALUE! |
| ***Operating Surplus (Shortfall)*** | ***18,279*** | ***-*** | ***#VALUE!*** | ***#VALUE!*** | ***#VALUE!*** |
| **Amortization of Tangible Capital Assets** | 260,135 | 242,887 | 40,891 | | |
| **Initiatives Spending** | | | | | |
| E-Health | 425,000 | 600,000 | | | |
| A@H | | | | | |
| Aboriginal Community Engagement | 5,000 | 5,000 | 5,000 | 5,000 | TBD |
| ED Lead | | 75,000 | | | |
| Wait List Management | | | | | |
| Diabetes | | 25,000 | | | |
| ER/ALC, Performance Lead | 96,264 | 100,000 | | | |
| Nursing | | | | | |
| *Other Initiatives (please specify - LHIN Operations only)* | | | | | |
| *Other Initiatives (please specify - LHIN Operations only)* | | | | | |
| **LHIN Operations and Initiatives- Total Actual/Planned Expense** | **4,538,512** | **4,989,601** | **4,475,473** | **4,597,609** | **4,757,961** |

# STAFFING PLAN

| Mississauga Halton<br>LHIN Staffing Plan | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| **Position Title** | **2008/09 Actuals as of March 31** | **2009/10 Forecast** | **2010/11 Plan** | **2011/12 Plan** | **2012/13 Plan** |
| **CEO** | 1 | 1 | 1 | 1 | 1 |
| **COO** | 1 | 1 | 1 | 1 | 1 |
| **Dir Finance & Risk** | 1 | 1 | 1 | 1 | 1 |
| **Dir Perf Imp & Integration** | 1 | 1 | 1 | 1 | 1 |
| **Dir Health Syst Dvlpt** | 1 | 1 | 1 | 1 | 1 |
| **EA** | 1 | 1 | 1 | 1 | 1 |
| **AA** | 2 | 2 | 2 | 2 | 2 |
| **Receptionist** | 1 | 1 | 1 | 1 | 1 |
| **Program Asst** | 1 | 1 | 1 | 1 | 1 |
| **Mgr Comm Eng & Communications** | 1 | 1 | 1 | 1 | 1 |
| **Sr Lead Funding & Allocation** | 1 | 1 | 1 | 1 | 1 |
| **Financial Analyst** | 1 | 1 | 1 | 1 | 1 |
| **Sr Information Lead** | 1 | 1 | 1 | 1 | 1 |
| **Mgr Corp Serv** | 1 | 1 | 1 | 1 | 1 |
| **Sr Lead Perf & Integration** | 3 | 3 | 4 | 4 | 4 |
| **Sr Lead Health Syst Dvlpt** | 4 | 4 | 4 | 4 | 4 |
| **Planning Analyst** | 1 | 1 | 1 | 1 | 1 |
| **Project Mgmt Support** | 1 | 1 | 1 | 1 | 1 |
| | | | | | |
| **Total** | **24** | **24** | **25** | **25** | **25** |
| | | | | | |
| **Position Title** | **2008/09 Actuals as of March 31** | **2009/10 Forecast** | **2010/11 Plan** | **2011/12 Plan** | **2012/13 Plan** |
| **Ehealth - PMO** | 1 | 1 | 1 | 1 | 1 |
| **Ehealth - Coordinator** | 1 | 1 | 1 | 1 | 1 |
| **Ehealth - EA** | 1 | 1 | 1 | 1 | 1 |
| **Total** | **3** | **3** | **3** | **3** | **3** |

# COMMUNICATIONS PLAN

## *Description*

The MH LHIN's 2010-2013 *Integrated Health Service Plan* (IHSP) released in November 2009, outlines a number of priorities and enablers for change to the health care system across the MH LHIN. The IHSP was developed through extensive community engagement and data analysis. The plan sets out broad strategies for the MH LHIN and will guide the activities up to 2013.

The Annual Business Plan (ABP) is a public document that outlines the MH LHIN's implementation of the IHSP and provides the basis of support for any regional transformation and associated funding realignments if required. The ABP also informs the MOHLTC's Results-Based Planning process which establishes the Ministry priorities and funding allocations.

Sharing the information in the ABP allows the LHINs and the government to work together to reduce duplication, enhance coordination and improve health care access across the province. It will also help the health care providers, stakeholders and public-at-large understand how the MH LHIN is planning to address the health care needs of the local community.

## *Key Audiences*

Release of the ABP will be of particular interest to the stakeholders who will be directly involved or impacted by the plan's strategies as well as the users of the health care system in the LHIN. It will also be of general interest to the broader public.

The list of stakeholders to be informed includes:

- LHIN Board and staff members.
- Ministry of Health and Long-Term Care.
- MH LHIN health service providers funded by the LHIN.
- Members of the Planning, Integration, and Advisory Teams.
- Aboriginals.
- French language health service groups.
- Local representatives of health care unions.
- News media.
- Public-at-large.
- Political leaders (Mayors, M.P.P.s, M.P.s).
- Local health-related special interest groups.
- Local health-related networks.
- Business and community leaders.
- Other LHINs.

## *Key Messages*

- This plan will assist the stakeholders and public in understanding how the MH LHIN is planning to address the health care needs of the LHIN region.
- The plans are based on extensive discussions the MH LHIN has had with members of the public, providers and stakeholders and on analysis of data on the local population's health status and existing services across the entire health care system.
- Stakeholders are actively involved in working with the MH LHIN on the strategies included in the plan.
- Specific messages about the content of the plan will be developed for the various communication tactics.