Appendix B Community Engagement Plan and Findings

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Mississauga Halton LHIN Community Engagement Plan

The Mississauga Halton LHIN began its engagement process in May 2006. There were two distinct phases that were undertaken.

Phase One – Creating Awareness and Engaging our Community – this phase can be characterized as strategies that the LHIN designed and implemented were to raise awareness of the engagement process and to listen to the public and providers. We characterized these as inviting public and providers to "our tables" to provide input and directions. The result of Phase One was a draft IHSP with identified priorities and action plans.

Objective	Strategies
To increase broad community awareness of the LHIN, IHSP and draft priorities	Local print media and cable TV
To engage members of our local communities	Public Forums – held in 6 different locations within our LHIN in the evenings
To engage members of our health care provider community	Provider Forums – held in 6 different locations within our LHIN in the afternoon
To advertise our forums to the public	Mail drop to 250,000 households
To listen to local priorities and integration opportunities	Board Members and Senior Staff attended meetings with all organizations/agencies/provider groups/networks that contacted the Mississauga Halton LHIN
To request comprehensive input and ideas around integration opportunities and readiness across all providers	Web survey – completed by providers
To request comprehensive input and ideas around health care needs and local priorities	Web survey – completed by members of the public
To provide an opportunity for providers and the public to make a written submission outlining integration opportunities and possible early wins	Written submissions

Objective	Strategies
To provide an opportunity for providers and the public to make a written submission outlining integration opportunities and possible early wins	Written submissions
To listen to presentations from providers and the public about integration opportunities and early wins	Delegations made to the IHSP Steering Committee which consisted of Board representation
To learn about cross-border organizations LHIN initiatives and for incorporation into the IHSP	Interviews with all neighbouring LHINs

Summary of Phase One Community Engagement Findings

The Mississauga Halton LHIN was committed to ensuring that planning and service integration was guided by the needs and viewpoints of both the users and providers of health services. To this end, an extensive community engagement process was carried out in May 2006.

The objectives of the community engagement process were:

1) To ensure that public and provider concerns are consistently understood and considered in shaping the future delivery of health care in Mississauga Halton.

2) To foster provider commitment to the common vision for integrated service delivery in the community.

3) To build public and provider momentum and enthusiasm for the local health care improvement.

Summary of Public and Provider Forums

Discussion forums were held in Etobicoke, Georgetown, Milton, Mississauga North, Mississauga South and Oakville. One public forum and one provider forum were held in each location (refer to the chart below for details). The public forums were held in the evening and were two hours in duration. The provider forums were held in the afternoon and were three hours in duration. A total of 328 participants attended the forums.

Location	Date
Oakville Oakville Town Hall, Trafalgar Room and Oakville Room	Monday, May 1, 2006

Location	Date
Georgetown Halton Hills Cultural Centre, Gallery	Tuesday, May 2, 2006
Mississauga Living Arts Centre, Bank of Montreal Room	Wednesday, May 3, 2006
Milton Country Heritage Park - Niagara Conference Room, Administration Building	Thursday, May 4, 2006
Etobicoke Centennial Park Community Centre - Banquet Room	Monday, May 8, 2006
Mississauga Canadian Coptic Centre, Trinity Hall	Tuesday, May 9, 2006

Each discussion forum began with a 30 minute educational presentation. The presentation covered the mandate of the LHIN and an overview of the IHSP. The remainder of the meeting time was spent in facilitated, small group discussion. As shown below, the discussion questions were structured differently for the public and providers.

DISCUSSION QUESTIONS FOR THE PUBLIC

Part 1: Improving the System

For each of the four life cycle stages (Mothers and Babies; Children and Youth; Adults; Seniors):

1) What is working well in our health system for people who need health services in this life stage?
2) What is not working well in our health system for people who need health services in this life stage? For example:
   - Are there any problems with coordination of services or how different services are connected?
   - Are there things that make it hard to get health services?
   - Are there any needed services that are not available?
3) Overall, what are what are the top 3 areas that should be fixed first to make our health system better? Why did your group pick these 3 areas?

Part 2: Approach to Moving Forward with System Integration

What will success look like? In other words, when we have our "integrated health system", what should be different for people who need health services and their families compared to what they experience today?

DISCUSSION QUESTIONS FOR PROVIDERS

Part 1: Approach to Moving Forward with System Integration

1) What are the conditions necessary to support partnership and coordination across sectors and organizations? How can these be achieved?
2) What does it mean to be client focused?
3) What will success look like at the local level? In other words, when we have our "integrated health system", what will be different for patients/clients/families compared to what they experience today?

Part 2: Identifying and Prioritizing Integration Opportunities

For **each** of the four priority areas (Chronic Disease Management; Mental Health and Addictions; Primary Health Care; Seniors Health and Wellness)

1) What are the two or three main challenges in this service delivery area that can be addressed with improved system integration?
2) What are the specific integration opportunities?
3) What other opportunities should be considered?
4) What are the **top five opportunities** that should be pursued first, and why?

The public was asked to comment on the health system using a simple, life cycle approach – mothers and babies, children and youth, adults and seniors. Providers were asked to comment on the four preliminary priority areas identified by the Mississauga Halton LHIN – chronic disease management, mental health and addictions, primary health care and seniors' health and wellness.

Although the public and providers examined the health system through a different lens, the issues and opportunities identified were remarkably similar.

System Improvement – Common Themes and Priorities

When community members were asked to identify opportunities for health system improvement, the following key themes emerged:

- Broad definition of "health" which recognizes the determinants of health (e.g. income, education, housing) and the need to collaborate with non-health sectors
- Health promotion, wellness, disease prevention
- Public education, beginning at a young age
- About health promotion, wellness, disease prevention and self-care
- About available services and where to get information
- About appropriate use of the health system
- About how to make a complaint
- Public and providers need access to better information about local health services

- Timely access to services, supports, information, test results
- Smooth transitions/system navigation
- Information Technology as an enabler
- Responsiveness to demographic makeup of Mississauga Halton residents
- Expand use of a broad range of health professionals and multi-disciplinary teams (e.g. nurse practitioners)
- Health human resources (work with education sector to increase the number of health professionals and to educate new health professionals differently; address wage disparities between community sector and hospital sector)

These themes are reflected in the top five priorities that emerged from the forums. The tables below show the high degree of consistency between the top priorities identified at the public forums and the top priorities identified at the provider forums.

PUBLIC TOP 5
1. More physicians, nurses, and other health professionals
2. Access – especially wait times
3. Health promotion, wellness, disease prevention supported by public education
4. Information for consumers about available services ("one number to call")
5. Information sharing across providers facilitated by technology and common client record

PROVIDER TOP 5
1. Health promotion, wellness, disease prevention supported by public education
2. Access – easy entry, no wrong door, no wait times, transportation
3. Information sharing across providers using technology and a common client record
4. System navigation by using care maps and mechanisms to smooth transitions from one service or sector to the next
5. Health human resources

There was widespread support for the priority areas shown above; however, there are also a number of issues that are a particular concern for specific sub-LHIN communities. For example, Mississauga is home to the largest Francophone population in the LHIN and access to services for this population is important for many residents. The Etobicoke participants feel that an urban health framework is required to address the community's rich cultural diversity and the challenges of poverty and homelessness. The rural communities of Georgetown and Milton placed high priority on transportation. Residents of Milton also gave high priority to services and supports to the deaf/hard of hearing, high risk obstetrical services, mental health counseling and expansion of the Milton hospital.

Providers were supportive of the four priority areas identified by the LHIN (chronic disease management; mental health and addictions; primary health care and seniors health and wellness). There was acknowledgement of the overlap across the four areas and the need for system-wide initiatives that cross all four areas (e.g. transportation).

Other potential opportunity areas identified by providers were:

- Infants, children and youth
- Palliative care
- Pandemic planning
- Diagnostic services
- Emergency departments
- Persons with disabilities
- Back office integration
- Health human resources
- Vocational rehabilitation
- Homeless population

Approaches to System Integration

Forum participants provided the Mississauga Halton LHIN with valuable advice on the process for achieving system integration. Community members painted a picture of what an integrated health system would look like. In the words of forum participants, an integrated system would offer *"the right provider for the right need"*, *"no wrong door"* and a *"system that knows you so that you don't have to know the system."* Key features of successful integration are described below. Again, there was a great deal of consistency in public and provider perspectives.

Public Perspectives

- One phone call to find and access services
- 24/7 access to services and information (including access for diverse groups)
- Easy to navigate the system
- System is seamless
- No waiting lists because services are timely
- Access to timely care within a reasonable distance; services available locally or transportation to those services that are available regionally
- Electronic health record
- Not being told that 'this is not our mandate'

Provider Perspectives

- Easy access to get services for patients by one number to get the needed support – public knows where, when and how to access care (including marginalized and diverse groups)
- System is seamless
- Providers are serving the appropriate population with the correct services
- Timely access; shorter wait times
- Integrated information system that supports sharing information across providers; one patient health record

- Patient-centered care; improved patient/client experience; physicians spend more time with patients
- More patient choice (based on information) and flexibility
- Focus on health promotion and disease prevention
- People take responsibility for their own health and the health care system
- Better information and knowledge sharing across providers
- Adequate health human resources; health care an attractive career choice
- Financial means does not impact access to services
- No extra charges for health services
- Funding supports local priorities
- Value for money; efficiency; no system abuse
- Use of best practices
- Intergovernmental cooperation to promote good health
- Focus on results/outcomes
- Easy communication with other professionals
- Trust relationships that promote exchange of information
- Service providers are less territorial
- Processes to bring providers together across sectors
- No unnecessary duplication of services (and savings redirected to enhance services)
- Sufficient resources and resources are allocated and aligned to priorities, including health promotion and disease prevention
- Greater cooperation in non-clinical areas (e.g. HR, IT)
- No financial competition
- Providers are innovative
- Patients and providers have trust in the system

Creating a Client-Focused System

Community members agreed that a more client-focused approach to care is clearly a desired outcome of an integrated health system. To further understand this concept, community members were asked to articulate what it means to be client-focused.

What it means to be Client-focused

- "Services fit the client rather than clients fitting the services"
- Providers are focused on how to make service/support a better experience for the client (e.g. evening hours of service; if necessary, services come to the client not the other way around)
- Providers know and understand client needs and their perspectives
- Providers put client needs before the organization's rules and criteria
- Provider mindset is: "its not about me"

- Providers personalize the journey of each client to ensure they feel more than just a number; services are individualized
- Providers take a holistic approach
- Services meet the cultural needs of the client
- "Customer service" focus
- Duplication is reduced (e.g. processes/tests/providing personal information)
- Client tells story one time and information is shared among providers
- Clients can access test results electronically
- Clients are educated and empowered to be involved in their treatment, care and decision making
- Providers engage clients more and allow them to have a say
- Clear delineation between clients responsibilities and providers' role
- Providers involve the client's "circle of care"
- Providers strive to strike balance between client needs and client wants
- Access is improved ("No wrong door")
- Clients move through a seamless system because providers actively identify clients in one sector that can benefit from services in another sector
- Clients have support to navigate the system

Establishing Partnerships to Move Integration Forward

Community members acknowledged that partnerships are critical to moving forward with integration. Partnerships should be inclusive and draw providers from across various sectors within health care. Cross sector participation (e.g. education, housing, social services, legal) was also viewed highly valuable. Partnerships will be facilitated by shared values, enablers and tools including:

Shared Values:

- Common vision, goals and principles
- Sustainable commitment (partnering is a long term proposition)
- Willingness to overcome organizational "turf"/traditions
- Attitude shift – focus on the client and "go beyond your silo"
- Understand the continuum of care and value each providers role in it
- Trust and respect for different professions, skill sets, knowledge bases, etc
- Honesty and openness
- Fairness (e.g. same rules for everyone in the partnership)

- Flexibility (e.g. willingness to challenge the original mandates of agencies and open to alternative methods of delivery)
- Good communication
- Common understanding of barriers, priorities and criteria for decision-making
- Action-oriented
- Value and build on existing experience and knowledge; retain current best practices

Enablers:

- System/sector champions to motivate and mobilize people
- Strong leadership
- Input from clients to drive what develops
- Incentives to encourage positive behaviours and results
- Opportunities to get together and appropriate venues to get to know each other
- Infrastructure to support partnerships including adequate funding and innovative funding models to support partnerships
- Education of partners (e.g. on client-focused approach)
- Accessible inventory of services/resources for all of Mississauga Halton
- Common language (e.g. all agencies use same language in their strategic plans)
- Consistent structures
- Common boundaries
- Agreement on standards of practice

Tools:

- Clear definition of "partnership"
- Service agreements to formalize partnerships and clarify roles and responsibilities
- Action plan
- Communication strategy
- Structures/mechanisms in place for partnering across boundaries
- Field visits/orientation programs to learn about partners
- Mechanisms to overcome "non-participating" barriers (e.g. too "thin" to spare front-line staff; follow up vehicle for small or poorly resourced agencies that can't attend all meetings; skepticism regarding reform initiatives)
- Common policy framework/directions

- Mechanisms to evaluate or "vet" potential opportunities for the partnership to pursue
- Mechanisms to facilitate information flow across providers
- Good metrics for measuring the success of the partnership

Summary of Web Survey Results

A web survey was created for both members of the public and health service providers. Specifically, providers were asked for input on the following:

- integration opportunities
- readiness across all health service providers to integrate
- decision making criteria for setting priorities
- potential for integration (horizontal and vertical)
- early win opportunities

The results indicated that the top five decision making criteria for setting priorities according to providers were:

1) Addresses a health need
2) Improves access to care and services
3) Promotes disease prevention and health promotion
4) Ensures that people move more easily through the seamless continuum of services
5) Incorporates evidence based practice

The public web survey consisted of questions around:

- decision making criteria for setting priorities
- top things that need to be fixed in the health care system
- interest in involvement in future LHIN initiatives

The results indicated that the top five decision making criteria for setting priorities according to public were:

1) Improves access to care and services
2) Addresses a health need (e.g. gap or underservice of a population)
3) Ensures that people move more easily through the seamless continuum of services
4) Positively improves the overall health system
5) Promotes disease prevention and health promotion

In total, over 300 members of the public completed a web survey and close to 100 health service providers completed the survey.

Summary of Written Submissions

An opportunity was given to health service providers and the public to submit a written submission outlining integration opportunities and potential early wins for consideration. This method allowed for comprehensive input and information gathering. Nine written submissions were received from a variety of organizations and sectors. The main topic areas included: integrated assessments and triage for specific disease populations; expanding partnerships across sectors; regional planning for optimal bed use; expanded concurrent disorder supports and family support programs; integrated chronic disease and prevention management model that includes holistic health; LHIN-wide PACS solution for integration of information; and achievement of diagnostic efficiencies across the LHIN. These were all considered and thoroughly reviewed.

Summary of Delegation Presentations

Although an ongoing opportunity exists to present integration ideas to members of the Board and Senior Team at the Mississauga Halton LHIN, a formal call for delegations was made. A few groups came forward and insightful conversations were had about: an integrated service delivery model for seniors' services across the Mississauga Halton LHIN; integration opportunities for special populations and services to meet the needs of residents requiring specialized services and/or those in other languages.

Following all of the engagement activities that occurred in Phase One, preliminary integration priorities were identified after "principled" decision-making criteria was applied. Action plans were also identified for each selected priority. A draft IHSP was then compiled and adopted by the Board of Directors. The draft IHSP was then used as the basis for Phase Two community engagement.

Phase Two – Testing the Plan – in the second phase, the priorities outlined in the draft plans were tested by returning to our community. This phase was focused on targeted engagement strategies to ensure that we engaged the public and providers at "their tables". The Phase Two engagement process resulted in continuous enhancement to the plan.

Objective	Strategies
To engage "experts" in recommending performance indicators per priority, and to give overall comments and suggestions on the Priority and Action Plans	4 Expert Panels

Objective	Strategies
To obtain a valid and reliable baseline on awareness and support for the IHSP initiatives and draft priorities	Telephone Poll
To increase broad community awareness of the LHIN, IHSP, and priorities	▪ Web site ▪ Local Media ▪ News Conference / press releases
Input from the Public involved in Phase One – confirm whether we heard what they had to say	Two VIP Public Forums
To increase input from targeted groups	Targeted meetings with: ▪ Physicians – Breakfast Meeting ▪ Francophone GTA Planning Day ▪ Senior Groups ▪ Service Clubs / Rotary Clubs ▪ Planning Councils ▪ Cultural Groups (Chinese Association of Mississauga, India Rainbow, MIAG, etc) ▪ Municipalities
To gain input from local Networks on their current initiatives and alignment with our IHSP and priorities	Survey sent to all local networks
Discussions with Consumers of the health care system on each of the specific priorities	Four Public Priority Discussions on: ▪ Improving Primary Health Care ▪ Enhancing Seniors Health, Wellness and Quality of Life ▪ Integrating Mental Health and Addictions Services ▪ Preventing and Managing Chronic Long-lasting Conditions
To get detailed input from providers and to ensure support for the plan forward	Provider Conference – September 28th
To gain input and advice from leaders within our local communities to help steer the successful completion of the IHSP	Creation of the *Integration Advisory Group (IAG)*

Summary of Phase Two Community Engagement Findings

Phase Two of the community engagement process took place during the summer and fall of 2006. The purpose of this phase was to get feedback on the draft IHSP and validate whether the IHSP reflected the input that was received in Phase One. It was also an opportunity to gather new issues and ideas from individuals who were not involved in the first round of consultations.

Public Perspectives

Public participants were supportive of the general direction of the draft IHSP. Community members reported that their views had been heard with regards to more of a focus on wellness, the need to remove barriers to access, the importance of increasing access to health care professionals and mental health and addictions as a priority area.

Participants felt that more emphasis on children and youth as a target group would improve the IHSP. Specific concern was shared about mental health and addiction services for children and youth, services for deaf children and the need to target health promotion initiatives at children and youth through the school system.

Other topics that the public suggested should be included or enhanced in the IHSP include the role of the consumer as an active partner, supports for cultural/linguistic diversity, reduced wait times, after hours care, increased use of nurses, nurse practitioners and pharmacists, home care and integration of health sectors.

There was recognition of potential barriers to success such as public and provider buy-in, lack of public awareness of LHINs, funding, lack of a common database and a good information system, communication, dissemination of information, problems accessing specialized services in other LHINs, creating multidisciplinary teams and changing attitudes.
The public felt that success of the plan would be reflected in more positive experiences with the health system such as shorter wait times, easier access, less fragmentation, better information sharing across providers and access to language interpreters. Suggested indicators to monitor success would address access to family doctors, hospital readmissions, referrals, emergency department wait times, consumer and provider satisfaction and service provider adherence to standards.

Members of the public are willing to be involved by participating in LHIN community engagement events, attending LHIN board meetings, spreading the word to others, helping to evaluate the success of the plan (e.g. providing input on LHIN accountability indicators, documenting their experiences with

the health care system, completing consumer satisfaction surveys), being "consumer champions" and influencing public policy.

Engaging the Francophone Community
As part of the engagement process, the Mississauga Halton LHIN IHSP Steering Committee received a delegation and a written submission from Le Centre Francophone de Sante Communautaire de Mississauga Inc on May 29, 2006. This provided an opportunity to hear about some of the local needs of francophone residents and specifically their efforts to establish a Community Health Centre.

The Mississauga Halton LHIN was an active participant in a large Greater Toronto Area (GTA) wide Francophone Community Engagement Forum on July 5, 2006. The 5 LHINs within the GTA (Mississauga Halton, Toronto Central, Central, Central West, and Central East) created this joint forum to give the Francophone community an opportunity to voice their health needs and health system issues which often cross LHINs. The information and ideas heard were considered by all of the LHINs as they developed their IHSPs. The issues that have been raised locally and across other neighbouring LHINs include the need to be able to access a continuum of services in French, from birth to end of life, from hospital care, primary care to home care.

This was the first of an ongoing dialogue between the GTA Francophone community and the 5 LHINs and proved to be an effective way to engage the community.

In terms of advice to the LHIN for future community engagements, several public participants indicated that their ability to provide input would have been enhanced had they had more detailed information on the content of the plan, written in easily understood language and preferably available in advance of community meetings.

Provider Perspectives

Providers took part in discussions organized around the specific priority areas in the draft IHSP. There was a high degree of support for the action plans in all of the priority areas as well as a numerous suggestions for improvement. Some participants felt that there was a need for a greater level of detail in terms of roles and responsibilities for specific providers, action steps and deliverables.

Providers, consumers and "experts" were also engaged and many participated on Expert Panels. The following is a list of the members of the Expert Panels:

Strengthening Primary Health Care

Yvonne Ashford
Kathryn Bamford
Edward Bennett
Lucia Cheung
Dr. Don Collins-Williams
Connie Day
Sandra Henderson
Dr. Marion King
Dr. June Kingston
Dr. Keith MacDonald
Dr. Garnet Maley
Dr. Lorne Martin
John Pereira
Angela Rea-Mahoney
Lina Rinaldi
Linda Rothney

Enhancing Seniors' Health, Wellness and Quality of Life

Ray Applebaum
Dr. Jan Boxall
Dr. Segaram Chandrakumaar
Joan Ciupak
Dr. Barbara Clive
Carolyn Clubine
Josee Coutu
Dr. Joey Edwardh
Dr. Stuart Egier
Mary Margaret Evans
Gisele Franck
Dr. Barry Goldlist
Dr. Margaret Grant
Carole Jones
Kim Kohlberger
Frances LaVigne-Henderson
Tini Le
Maureen Lynn
Lynda Perry
Jane Richardson
Tiziana Rivera
Dr. Lynne Robinson
Dr. Greg Thomson
Carol Ward

Preventing and Managing Long Lasting (Chronic) Conditions

Yvonne Ashford
Cathy Benbow-Plewes
Ann Boucher
Gayle Bursey
Daniela Catallo
Stacey Horodenzny
Ericka Hosang
Helena Hutton
Dr. Nick Kates
Dr. Michael Kates
Nabila Lowe
Jan MacRae
Inga Mazuryk
Lynne McTaggart
Mary Merry
Allan Mills
Dr. Stephan Mostowy
Helen Ross
Dr. Danny Sapir
Colette Sewell
Dr. George Southey
Megan Ward
Dr. George Wu

Integrating Mental Health and Addictions Services

Joan Barham
Julia Baxter
Margaret Bickerton
Lucia Cheung
Carol Hennigar
Dr. Roman Jovey
Terry Mc Gurk
Seth Moyse

Integrating Mental Health and Addictions Services
(Continued)

Peter Croxall
Diane Doherty
Dr. Dianne Giacomelli
Gerald Gignac
Kristina Hall
Ron Rogers
Dr. Colin Saldanha
Ian Stewart
Charlene Winger

A summary of the key comments from the Provider Conference and from the Expert Panel sessions is provided below.

Strengthening Primary Care

Improving the Action Plans

Providers were generally in agreement with the proposed action plans. Suggested areas for improvement include:

- The LHIN is under funded per capita; we don't have the resources to do this; the continuum of care initiatives will be difficult to achieve without an age/sex/income adjusted funding formula
- Education - Need to include opportunities to educate the community about the plans
- Health Human Resources
  - Need to identify where administrative support will come from
  - Plan around capacity – most groups are at maximum capacity now; how to deal with growth?
  - How to ensure that the health care organizations in the LHIN train, recruit and retain enough family physicians and other professions (e.g., NPs)?
  - Definition of inter-disciplinary should be broadened to include volunteers and outreach workers in the inter-disciplinary team
- Actions Plans 1 and 2 missing midwives
- Infrastructure tools and information required to fully deploy a high functioning primary health team
- E-health initiative is necessary to make this work
- Transferring of health information – confidentiality; security; privacy; how to pay for this efficiently and effectively without taking funds out of health delivery – also compatibility across sectors
- Data gathering is an enormous challenge and identifying providers will be difficult
- Families that do not have doctors; how to access services without a physician

- Need to identify whose responsibility it is to help the patient navigate the system (not referenced anywhere); especially when there is no family doctor
- Addressing the disabled, and marginal/at risk/hard-to-reach groups across the continuum of care –e.g. some family doctors' offices cannot be accessed by wheelchair.
- Involvement of other partners (e.g. Ministries, Agencies, Public Health Units)
- Develop a realistic set of deliverables
- Keep action plans realistic for implementation
- More of a "health promoting" perspective needs to be integrated into the Primary Health Care model (more holistic approach to healthy body, mind, and spirit)

Challenges

- Sustainability
- Education and Awareness
- How to engage the community at large (don't re-invent the wheel)
- Involvement of other Partners
- There is a lack of health promotion which will eventually lead to prevention
- Public Health is not funded by the LHINs
- Engaging/connecting solo practice physicians into the integrated system
- Overcoming the public resistance to seeing allied health professionals rather than their GP/FP
- Establishing new partnerships across boundaries that have not previously existed (referral patterns across LHINS); key health partnerships are not aligned with the LHIN boundaries
- How to ensure gaps are addressed
- IT systems throughout the health system will need to be compatible/standardized and easy-to-use for this to work
- Accessibility, distribution and confidentiality issues with transfer/sharing of a person's health information between the hospitals, community, independent providers.
- Re Action Plan #2: the region does not get its fair share of resources on a per capita basis (e.g., birthing/new moms in public health – public health services are not in place to receive support from the community when moms come back from delivering their babies in downtown Toronto).
- After hours and weekend availability for non-urgent services

- Decrease time for diagnostic tests – faster turnaround

Potential Performance Indicators

- Canadian Institute for Health Information (CIHI) Primary Care Indicators Project
- Wait times for primary health care
- Institute for Health Information website; children's website for indicators
- Emergency Department utilization and length of stay
- Service Volumes
- Clinics
- Emergency Departments
- Number of people without family doctors
- Number of newly recruited physicians
- Number of moms that access services
- Number of deliveries
- Age of diagnosis for developmentally delayed

Initiatives that could be leveraged

- Public health departments could be tapped as a source for primary health care (e.g. sexually transmitted diseases)
- West Cluster Child Health Network – model for shared education; standardized policies
- Child Health Network website provides access points
- Greater use of Community Health Centres; youth transition; use them for prevention – providing education and promoting prevention for all demographics (e.g., after-school programs); funding should be leveraged and distributed across the continuum
- New medical teaching program at Credit Valley Hospital and Trillium Health Centre that will include a Family Practice Teaching Unit at both hospitals
- Standardized Pathways that currently exist (e.g., Hip and Knee Replacement) – aims to educate the patient before they get admitted for the procedure.
- National Primary Care Partnership Project – case managers to play a pivotal role in identifying agencies (system navigation role)
- Information sharing through existing agencies; rounds; advocacy groups

Involvement of Providers Going Forward

- Support, encourage key providers in the community
- The Ministry should provide start up funds and provide them in a timely flow of cash
- We need to remain critical and to challenge the status quo
- To have further measurements of outcomes
- We should leverage the use of non-professional people – to build volunteer base for education and health promotion
- Education of cultural differences and expectations to other providers
- Disseminate information about the LHIN and action plans widely

Enhancing Seniors' Health, Wellness and Quality of Life

Improving the Action Plans

In general, providers had a positive response to the action plans. Specific strengths identified include the end-of-life strategy and the proposed joint governance which will provide a voice to everyone, and for everyone to provide input. Providers recognized the implicit understanding that the model will evolve as experience in implementation builds.

Some providers were seeking more detail on funding arrangements and linkages/relationships across the different components of the model.

Suggestions for improvement include:

- This is an organization structure – what we need is to address service delivery needs
- Needs to be well resourced from the beginning; staff of existing agencies can not continue to "volunteer" their staff resources to this initiative
- Common assessment tools and case management would be useful across all initiatives; portability of information is long overdue
- Increased LTC capacity required
- Should have more representatives (4 rather than 2) in the governance structure
- Ensure that psycho-social counseling is on the agenda for those in LTC homes
- Increase the number of nurse practitioners who can go to LTC homes
- Consider complementary/ homeopathic needs in LTC
- There is a need to enhance the skills of existing LTC staff before attempting to employ advanced practitioners

- Recognition that end of life spans all age groups – i.e. not just seniors
- Care coordinators should be available across all priorities, not just seniors
- Public education (e.g. shift away from entering the system at the emergency ward)
- Need a separate action plan on community based care
- Community support services are missing (e.g. transportation)
- The plan does not address supportive housing or answer the question "how do you keep people at home"
- CCAC is an integral player in the new set up

Challenges

- Communication
- Education of the public is required, as well as providers
- Need for a marketing campaign to make sure that the people are informed enough to utilize the proposed structure
- Need to support capacity development for involvement in the process
- How will consumers know about all the various agencies?
- How do we know what other services are out there?
- Transportation barriers
- Cultural and educational differences
- Access for rural communities
- E-health strategy and technology will be needed to support implementation
- Request for an IT base that is accessible by all agencies for all services for seniors (and keep it updated!)
- Challenge of how people deal with and access privacy issues
- Health human resource challenges
- Human resource strategy and a model that is not bureaucratic but consumer driven
- Need a shift in thinking from funding to consumer focus
- LHINs must be held accountable to ensure implementation
- Large task with many complex issues
- Need to make sure that the existing strengths in the system aren't duplicated
- Sectoral issues: traditional silos need to be broken down
- Funding is an ongoing challenge
- Transfer of information across sectors needs to take place

- Mindset that integration will mean a loss of control
- Palliative care should be put into LTC homes and hospice rather than hospitals
- Long term care is a place that palliative care is rightly placed

Potential Performance Indicators

Short-term:

- Client/Caregiver satisfaction
- Provider satisfaction
- Care transition measure
- Number of people who do not know service exist – population-based utilization
- Wait times for health services
- Number of health care professionals per population
- Admissions per case mix group specific/critical to population
- Clinical independence function scores • objective measures for function
- End-of-Life scores; palliative performance scale

Medium-Term:

- Client/Provider Satisfaction
- RAI data • support for clinical pathways
- Prevention indicator
- Medication errors
- Falls
- System navigation/process evaluation

Longer Term:

- Client/Provider satisfaction
- Size and type of wait list for LTC filtered by population
- Alternate Level of Care days for people waiting for LTC placement
- Inappropriate admissions to hospitals
- Utilization of hospitals for palliative care
- Proportion of population cared for by Family Health Team/Family Health Group

Initiatives that could be leveraged

- Programs need to leverage the role of the CCAC and how it can facilitate this model
- Long term care is already taking on enhanced roles (e.g. accommodating dialysis); need to strengthen linkages from community services and long term care
- Opportunity to leverage the common assessment tool
- Existing transportation networks could be enhanced
- Education programs such as those at community health centres
- ‘Falls Program’ has been effective and could be leveraged
- 10 nursing best practice coordinators in the province; 50 psycho-geriatric consultants in the province; also palliative care consultants
- Convalescent Care, Respite Care, and Short Stay programs
- Georgetown supportive housing program: support service coordinators work with clients in their home, supporting aging in place
- Some LTC homes (e.g. Dom Lipa) have excellent end of life care – could be used as a benchmark or pilot study

Involvement of Providers Going Forward

- Being present and involved with an open mind
- Consultants, advisors, experts
- Keeping the client perspective in mind at all times
- Bring our own expertise to the table; participation in committee work
- Delivering the message to our community; community partnerships
- Those agencies that already host system navigation services are willing to come together and contribute to the process of refining the system navigation services for the LHIN
- Public health assistance and participation in prevention initiatives

Other Issues/Suggestions for the Overall IHSP

- Overview of how it all fits together.
- More emphasis on quality of care
- Health human resource plan including strategies for recruitment and retention
- Volunteer Coordination and leadership

- More emphasis on the health needs of women and children (not clear why some populations are priorities and not others)
- More specific action plans regarding children and youth
- Strategies missing to reach the "hard to reach" and "at risk" populations
- No reference to an accessibility plan; broad definition of accessibility should be included in the plan (e.g. language, impairments)
- Include secondary and tertiary care
- e-Health needs to go across all plans
- Program evaluation and qualitative evaluation across priorities.
- Health promotion and disease prevention; broader definition of health determinants
- How programs that cross more than one LHIN will be handled
- How will the LHINs integrate with other Ministries (e.g. Education; MCSS) what they do or not do will impact health (e.g., housing impacts health); health promotion; health and safety early on in the schools
- An inter-disciplinary advisory committee is required to deal with regulatory enablers to achieve integration across the sectors (professional navigation)
- Danger is that we create new silos; need to rethink how we see people in the system and think horizontally across boundaries
- Cost analysis needs to be completed
- Supply/demand analysis across LHIN
- LHIN needs a communication strategy to keep people informed
- Greater awareness – need a portal with listings of agencies
- LHIN should have consumer representation on the coordinating council
- Need to develop sub-working groups to bring people together

Preventing and Managing Long-Lasting (Chronic) Conditions

Improving the Action Plans

There was general agreement with the proposed Action Plans, particularly Action Plan #1 (develop model) and Action Plan #2 (care pathways). Some physician participants felt that CDPM was critical to alleviating pressures in the acute care system and curbing the increasing demand for health care brought about by population growth and aging.

The top suggestions for improving the CDPM action plans related to the focus on "rehabilitation", the need to distinguish between prevention and

management, the need for greater emphasis on the prevention and the importance of establishing centres of health care excellence.

While some providers were very pleased to see the focus on rehabilitation in Action Plan #3, others were concerned about what was perceived as a very narrow focus on "rehabilitation". The rationale for the focus on rehabilitation was not clear to all participants and some felt that the term "rehabilitation" referred only to care provided by rehabilitation professionals. Some felt the focus should be broadened to "supportive care" and others suggested that the focus should be on case management. The need for clarity on where the rehabilitation will take place was also suggested.

Many providers felt it would be beneficial to look at prevention and management separately (they are very different but need to be linked) and in greater depth. Providers also stressed the need for more emphasis on prevention/wellness including risk factors and environmental issues. Some providers felt that a "dual strategy" was required to address both specific diseases and broad risk factors. The importance of working closely with public health and with sectors outside of health (e.g. parks and recreation, education, labour, etc) on the prevention component was reinforced.

The need to consider virtual centres of excellence that would centralize programs for specialized chronic illnesses was a common theme voiced by service providers. Since there are too many different chronic conditions to have the requisite expertise and critical mass required for safe care everywhere, it will be important to bring specialized expertise together in centres of excellence.

Other suggestions for improving the CDPM action plans include:

- Addressing the role of the patient (e.g. self-management)
- Clearer definition of the community role
- More emphasis on building a "system" (including infrastructure and capacity and more solid outcome measures)
- Need more emphasis on case management, coordination and system navigation
- Need more emphasis on CDPM through information technology
- Need to link to palliative/end-of-life initiatives (some participants felt that palliative care was a better fit under CDPM than under seniors)
- Need to incorporate cultural aspects of chronic disease into the model and access for non-English speaking communities
- Need to address alternative medicine/complementary therapies
- Care pathways should be: multi-system/disease pathways; flexible; easy to follow; individualized for the patient and based on patient goals; based on different life stages and illness stages
- Need to consider the age continuum

- Need to distinguish between "service pathways" and "clinical pathways"
- Important to create a system that is seamless for the clients and that all providers "speak the same language"
- Local CDPM models should be consistent across the province
- Consider a broader process of identifying an implementation leadership "team" or "partnership" rather than a single organization
- Mixed views on the proposed timeframes – some participants felt that a 3 year roll-out was fine but others felt that the environmental scan component could be accelerated to expedite early results
- Need integration with other ministries (Social Services, Housing, Education)

Challenges

One of the biggest challenges identified for moving forward with CDPM is the coordination that will be required across a wide spectrum of stakeholders, particularly health providers that are not within the LHIN funding envelope (e.g. public health, disease-specific associations) and non-health sectors (e.g. (e.g. parks and recreation departments, education, housing). Another challenge related to the broad spectrum of chronic diseases is how to prioritize specific diseases and their management.

- System barriers – Breaking down the silos and making the link between CDPM and other priority areas; resource allocation; wait times; declining number of family doctors; orphan patients; transportation, delisted services that support CDPM (e.g. optometry)
- Information management - Data collection, lack of data in some areas, need a mechanism for tracking the individual through the system; need for common definitions
- Performance measurement -How to measure effectiveness of prevention measures (e.g. Development of tools that quantitatively measure outcomes and effectiveness); standardized outcome measures that are comparable across LHINs
- Changing service delivery approaches - Coordination of inter-disciplinary teams; physician involvement and comfort levels; cultural shift
- Increasing public awareness and patient education (e.g. disease screening) - challenges include people learn differently and many people do not pay attention if they are not sick
- Addressing at-risk populations – focusing on the social determinants of health and reaching the most vulnerable populations
- Need to focus more attention on dialysis (especially dialysis provided in the home or in ambulatory care settings) and address the varying approaches that currently exist for management of renal disease

- Confusion between LHIN role and provincial role for specific chronic diseases

Initiatives that could be leveraged

- Leverage strategies that could be transferred from other diseases (e.g. cardiac care model)
- Leverage existing networks and partnerships (e.g. Halton Peel Palliative Care Network)
- Leverage existing CDPM projects (e.g. PRISM, National Primary Care Partnership Project, Patient Self Management Program at Trillium Health Centre , Marginalized Women and Stroke Project)
- Leverage data that is available on current services
- Existing clinical best practices and care plans (e.g. Diabetes)
- Wait time strategy in relation to chronic disease issues
- E-health initiatives
- New Convalescent Care Program
- Success of Alzheimer's Society in bringing groups together
- Learnings from Kaiser Permanente
- Family Health Teams
- Community rehabilitation specialists
- Consumer health information
- Quality improvement initiatives
- Communities of practice for diseases

Involvement of Providers Going Forward

Providers offered the following potential roles for moving ahead with the CDPM action plans:

<u>Planning:</u>

- Participate
- Support
- Champion
- Advocate
- Identify gaps and duplication in the system
- Demonstrate openness to collaborate with other providers
- Share information and clinical expertise

- Provide feedback (e.g. LHIN should consider soliciting feedback via email; meetings not always required)
- Provide pragmatic advice
- Establish trust

Implementation:

- Implement action plans
- Provide client-centred care
- Be open-minded and learn more and new ways to deliver care
- Commit to education of the public for self-management and prevention
- Support cultural shifts and enable that to happen
- Change attitudes
- Partner with other organizations to refine best practices
- Commit to consistent messaging for patients

Integrating Mental Health and Addictions Services

Improving the Action Plans

Participants were quite supportive of the action plans but many felt that Action Plan #2 should drive Action Plan #1 and needs to come first. Action #2 should link to the Building Blocks in the vision more closely.

Other suggestions for improvement include:

- Need to better recognize the cross-ministry/cross sector nature of service delivery in this priority
- Emphasize that the cost of addictions to the system - $9 billion in Ontario
- Enhance the Addictions (including gambling, drugs and alcohol) aspect of the plan considerably
- Develop a tool kit of standard assessment tools, built on best practices, for each of: mental health, addictions and concurrent disorders
- Ensure that there are succinct versions of tools, built on best practices, for use in primary care
- Develop a common education plan that is purposeful and coordinated across providers
- Recognition that Mississauga Halton LHIN is below the provincial average in terms of mental health and addictions resources and requires greater coordination and planning; possibly need to build a business case to address deficit situation
- Need to include concurrent disorders and dual diagnosis in the action plan

- Recognize that systems are needed for increased inter-agency/institution communication
- Hospital Emergency Departments need better communication links with community service providers and consistent basic service levels to deal with this population more effectively
- Greater cultural sensitivity and recognition that language needs are not being met
- Include a shared care model
- Place more emphasis on case management
- Address MH&A wait times
- Need a strong mental health and addictions planning table with consumer input
- Need to recognize the level of integration and collaboration needed within Mental Health, within Addictions, within Mental Health and Addictions and between MH&A and the rest of the health system
- Need to address MH&A within the other priority areas (Seniors, Primary Health Care and CDPM)
- Consider including education on Mental Health and Addictions in elementary and secondary schools
- Incorporate volunteers into the action plans
- Need more emphasis on prevention and promotion in the plan

Challenges

- Lack of psychiatrists
- Lack of follow-up support post hospital discharge
- Most children's Mental Health is funded by Ministry of Community and Social Services; youth transition to adult services is very difficult
- More funding is needed as we cannot do the job today and greater demand for services will result from this priority at the Primary Health Care level and beyond
- There is a significant disparity across Mental Health and Addictions today
- There are significant disconnects across providers/institutions/agencies/sectors
- Family Health Teams lack current linkages to the community and the social determinants of health
- Family and client service poorly supported
- Difficult to challenge the funding flows without a well-defined process
- Coordination of multiple telephone support services (e.g. confusion between Telehealth Ontario and 2-1-1 services; 22 crisis lines)

- Moving resources from one area to another that is in need
- Transportation of clients is a significant challenge
- Provision of a full range of specialized services in the LHIN without an academic medical institution; access to regional programs (e.g. CAMH)
- Stigma associated with MH&A
- Resources to support the process of change
- Structures of accountability/liability to support collaborative relationships
- Criteria for access is an issue
- Need to make services more user-friendly

Potential Performance Indicators

- Client-focused measures
- Wait times for MH&A
- Average length of stay in hospital
- Consumer/survivor/family satisfaction
- Number of patients served
- Number of assessments
- Client health status pre and post service
- Number of clinical problems presenting
- Discharge plans in place
- Number of service agreements (across providers, across sectors, across ministries)
- Number of inter-agency agreements and co-location arrangements
- Diversion rates from hospitals
- Number of referrals
- Number of referrals followed through with service provision
- Market share

Initiatives that could be leveraged

- Mental Health & Addictions Leaders Forum for Mississauga – Halton
- Peel Crisis Capacity Network
- Learn from best practices
- Trillium Health Centre centralized in-take system
- Addictions common intake and discharge assessment tool
- Waterloo Wellington Community Development model

- MH&A partnering with Family Health Team and Community Health Centre
- Leverage existing memorandums of understanding (MOU).
- Broaden community support agreement with addictions.
- Leverage COAST initiative beyond Halton.
- Leverage experience of development of the nurse practitioner role
- Use of video conferencing to work with clients
- Build on what is working well today and do not reinvent the wheel
- Acton Community Support and Treatment Team in north Halton could be leveraged across the LHIN

Involvement of Providers Going Forward

- Participate in forums, on design teams and any leadership groups
- Build on the MH&A Leaders group and plans for system design
- Commitment to the vision and make it work
- Active partnership with primary health care
- Create a local passion to develop volunteer programs
- Work together
- Advocate and educate for one system
- Ensure partners are at the table
- Implement the action plans as they roll out

Summary of Network Survey Results[1]

A survey was sent electronically to all known local networks soliciting information about their networks' initiatives which align with our local integration priorities. Numerous surveys were completed and a summary table in Appendix H outlines the alignment. Overall, there are networks that have initiatives that align with each of local priorities and action plans which can be leveraged.

Networks will be an important vehicle as we move forward with implementation and many of them will support success. The networks and their initiatives that align with our action plans have been included in the detailed priority and action plans in Appendix G.

[1] To see full details please refer to Appendix H

Market Research Poll

Methodology

Leger Marketing conducted a study of the opinions and beliefs of Mississauga Halton LHIN area residents concerning their local health care system. Data collection for the study was conducted via CATI telephone interviewing during the time from August 21 to September 6, 2006. A randomly-selected, representative sample was achieved by inviting catchment residents aged 18 years of age and older to complete the survey. A total of 601 interviews were completed. The margin of error for a sample of this size is +/- 4.0%, 19 times out of 20. In order to ensure the statistical reliability and comparability of regional results, a regional quota regime was employed as illustrated in the following chart. However, the final data are statistically weighted using the most current Census and government data to ensure the results are representative of the actual population of the Mississauga Halton LHIN catchment.

	Sample Size	Margin of Error at the 95% confidence level
Total (Mississauga-Halton LHIN)	**601**	**±4.0%**
Mississauga	269	±6.0%
Oakville	112	±9.3%
Rural (Georgetown/Acton/Milton)	110	±9.3%
Etobicoke	110	±9.3%

Summary of Results

Overall, the results of the poll showed that there was high to moderate satisfaction with and confidence in local health care in the Mississauga Halton area, which depicts a positive public opinion context for the LHIN. Notably, unaided awareness of LHINs was low, although half of residents said they were aware once provided with a description. Coupled with this low level of awareness was a resident demand for more LHIN information. There was strong support for key priority areas, such as primary health care, improving performance, and preventing and managing chronic diseases. The residents of the Mississauga Halton LHIN have high expectations for an integrated local health care system that focuses on wellness, and involves patients in decisions about their own care.

Residents of the Mississauga Halton LHIN were generally satisfied with and confident in key aspects of their local health care system. The majority of LHIN residents were moderately satisfied with their local health care system. No less than seven-in-ten are satisfied with the overall quality (86%), accessibility (76%), efficiency (72%), and coordination (73%) of the local health care system. Furthermore, a quarter or more are very satisfied. There was also high to

moderate confidence in local health care. No less than six-in-ten are confident in the sustainability of the local health care system (80%), that it will improve in the future (67%), and that a workable plan for local health care exists (56%). Moreover, 17% to 32% of residents are very confident.

In terms of awareness, half of LHIN residents had seen, read, or heard about changes that are being made or will be made to how health care services in their community and across the province are planned, managed, and funded (51%). However, among those that were aware of changes in the health care system, only 3% were aware of LHINs without prompting. With prompting, one tenth of LHIN residents were aware of LHINS (15%). Once they heard a description of LHINs, one quarter of LHIN residents said they were aware (25%). However, only one in ten LHIN residents were somewhat to very familiar with the LHINs or the Mississauga Halton LHIN in particular (12%). LHIN residents who had seen, read, or heard something about LHINs over the past two years reported an awareness of a new (22%), team-based approach (22%), and a move to local control of health care planning (9%).

There was strong support for key LHIN priority areas among Mississauga Halton residents. The majority of LHIN residents said that all priority areas were very important, and all key priority areas were considered important by at least nine in ten LHIN residents. Yet, a ranking of priorities may still be discerned from the results. The primary tier of support for key priority areas included primary health care (27%), improving performance (23%), and preventing and managing chronic diseases (22%). This was followed by support for enhancing the health and wellness of senior citizens (16%) as a secondary tier priority, and mental health and addictions services (6%) as a tertiary tier priority. After discussing health care and the LHIN priorities, there was no consensus re: any missing priorities. Indeed, 60% responded "No/Nothing" and the remainder mentioned issues already addressed by the LHIN's key priorities tests.

The low level of awareness of the LHIN may have prompted a desire for more information among Mississauga Halton residents. Over four in five LHIN residents want more information about the LHIN (85%).

Mississauga Halton residents have high expectations of their local health care system. When it comes to engaging the public, patients want a more active and empowered role in making decisions about their own health care (93%). On a broader scale, seven in ten (69%) residents thought that decisions about the health care system are already based on local interests and needs, but only half (46%) thought they currently have enough input into health care planning. There was high, strong support for team-based health care provision (98%), integration of the system (95%), and increased coordination of health care services (91%). As well, there was high, strong support for quality standards across the system (97%), and for a new focus on proactive wellness-based approaches (89%).

Our first Integrated Health Service Plan has evolved and improved through out phase one and two as a result of engaging the public and providers. As a result we have a plan with broad support and shared commitment for action.

Integration Strategy

Integration is not an end in itself, but a journey – it is the process that will be used within the Mississauga Halton LHIN to achieve our (paraphrased) vision of 'healthy people and healthy communities through a well coordinated service delivery system that is sustainable.' Creating an integrated health system will require shifts in how we work together and deliver care to meet the health needs of our local communities. The role of the Mississauga Halton LHIN is to promote and facilitate appropriate integration. It is expected that opportunities for integration and system improvement will be proposed by those within (providers) and those using (the public) the healthcare system.

The Mississauga Halton LHIN will continue to consider both horizontal and vertical integration opportunities in order to deliver needed services to our client/patients/families[2] and communities. Horizontal integration focuses on establishing relationships among like organizations for the organization, coordination, management and/or delivery of services. Horizontal integration is viable for the elimination of inefficiencies and redundancies or for effectively managing high risk, low volume activities through the consolidation of skill, competence, experience and technologies. Vertical integration is the networking of organizations to provide a continuum of services to a defined population, by being held accountable for the outcomes and health status of that population. The focus of vertical integration is on the provision of the right services, delivered at the right time, in the right place by the right provider in order to meet the needs of our patients in our communities.

Opportunities must align with the strategic goals for integration as outlined below.

Strategic Goals

1) All providers will embrace a systems perspective, through language, actions and accountability for joint outcomes in the delivery of high quality client/patient/ family-focused services for the residents of the Mississauga Halton LHIN.

2) Improve access to the care and services needed by our community.

[2] Client/Patient/Family refers to any Patient, Client, Survivor, Resident, Consumer and other individuals who may potentially use health services.

3) Ensure that our clients/patients/families can move more easily through the continuum of services.

4) Promote sustainability of the health system by ensuring the most effective and efficient use of our resources.

Decision Making Criteria for Setting Priorities

A set of decision making criteria were developed to support a `fair and transparent' approach to decision-making and to ensure that the interests of many (Ministry, local needs, the public, providers, our partners and best available evidence) are balanced effectively. These were validated through community engagement. The following are the principles that guided the development of the IHSP and will continue to support decision making efforts in the execution of the IHSP.

- Addresses an identified health need of a population.
- Promotes disease prevention and health promotion.
- Incorporates evidence based practice.
- Demonstrates innovation in service delivery.
- Contains elements demonstrating true partnership and collaboration.
- Improves access to care and services.
- Ensures that people move more easily through the seamless continuum of services.
- Improves potential for the financial sustainability of the health care system.
- Positively improves the overall health system.
- Within the legislative and fiscal mandate of the Mississauga Halton LHIN