Trillium Health Partners

A new kind of health care for a healthier community

Better Together

Our Strategic Plan (2013-2018)

Contents

Our Call to Action – Better Together

We all want to be well and as healthy as we can be – at every stage of our lives.

We envision a new approach to health – an inter-connected system of care that is organized around the patient, both inside the hospital and beyond its walls. An approach that provides excellent care today and continued leadership for improving care tomorrow.

Working together to realize this vision, we will continuously ask ourselves what it will take to make a healthier community and dare to imagine innovative ways to achieve it. Our focus will be both on keeping people healthy, and on treating and caring for them when they need it most.

Building on the best of what we do, we will think and act differently in order to further improve our services. We will continuously demonstrate compassion, excellence and courage in the pursuit of our mission.

That means we will be with our patients and their families at every step of their journey, caring for them and helping them to access health support, while creating a learning environment in which we can deliver the highest quality of care possible. We will invest the precious resources of this community in the most effective ways possible.

We are all in this together. And as partners in creating a new kind of health care, we are ***Better Together***.

Health Care for Our Community – New Challenges, New Opportunities

The Broader Health Care Environment: The Case for Change

Over the last decade, we have focused on finding new ways to deliver higher quality, more accessible and more efficient care, within hospital walls, to meet the needs of one of the fastest growing communities in Canada. As a result of many innovations over the years, we have become one of the highest performing hospitals in the country in terms of both quality of care and efficiency. These improvements are directly contributing to better patient care.

Up until now, our efforts have enabled us to meet the growing needs of the population and provide quality hospital care despite increasing pressure. Looking to tomorrow, however, we will require new thinking and action to address our challenges. Business as usual is no longer an option if we want to maintain and improve the quality, accessibility and sustainability of health care. We face a number of challenges that affect the whole care system and impact our ability to deliver exceptional care to our community.

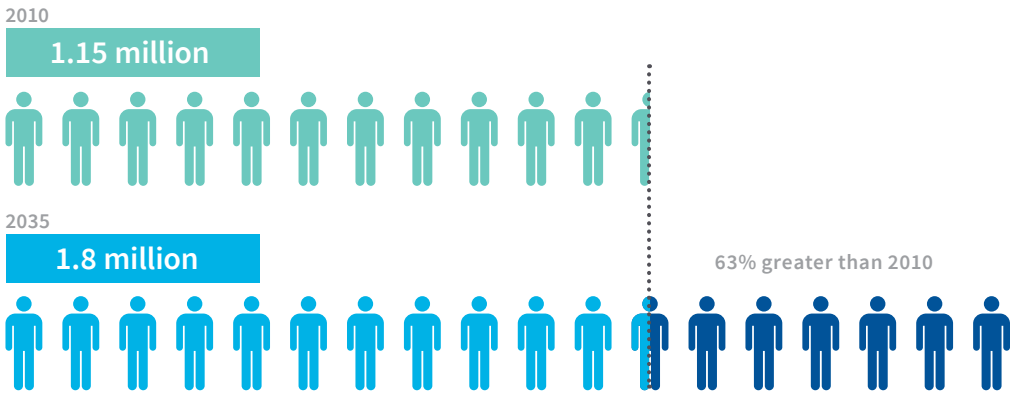
OUR CHALLENGE: A GROWING & CHANGING POPULATION

What We Have Heard:

- It will be more and more difficult to meet growing health care needs
- We have a diverse community with unique needs – we need to respect these needs
- Our aging population requires more health care than ever before

An additional 650,000 people will be living in the Mississauga Halton region by 2035 [(1)], amounting to a population of 1.8 million people - larger than most urban centres in Canada today. This increase in population is driven by urban growth, new births and new Canadians settling here, with children and seniors as the fastest growing segments.

Our Population Profile



63% overall growth in the community by 2035
50% growth in children by 2035
175% growth in seniors by 2035
43% of all health care expenditures in Ontario account for seniors care

Medical discovery and advancement has meant that more people are living longer. Baby boomers already represent the largest age group in Canadian history and they will live longer than any previous generation [4]. Further challenging the situation is the reality that a senior citizen, on average, consumes twice as many health care resources as the average individual.

KEY FACTS:

- Chronic disease accounts for 79% of all deaths in Ontario [5]
- For almost half of our community, English is a second language and over 50 languages are spoken in this region [6]

In our growing and aging community, there is an increased prevalence of people living with chronic disease [5]. Today, diabetes, cancer, heart disease and respiratory disease impact the quality of life of many Canadians and residents of our region. As our population ages, an increasing number of residents in our community will require care and support for chronic diseases. For our region, this reality is further defined by rich diversity and unique health care needs. We have a large immigrant population in our region, representing a wide variety of ethnicities. For some, specific diseases are more prevalent, such as diabetes and hypertension in South Asian populations [7].

To effectively address the pressures of growth and changing demographics in the region and to create a more sustainable, high quality and accessible health care system, we need to think differently about how we deliver services.

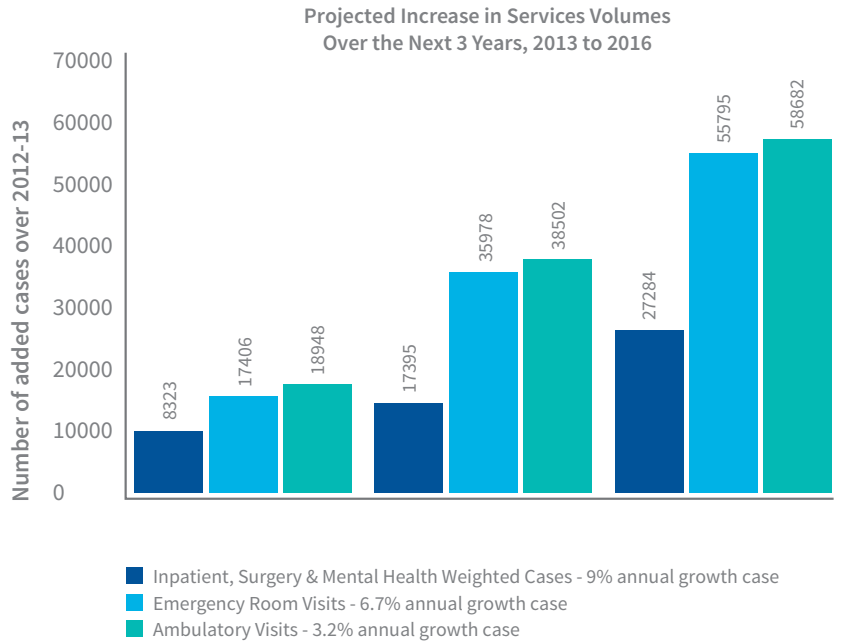
OUR CHALLENGE: CAPACITY

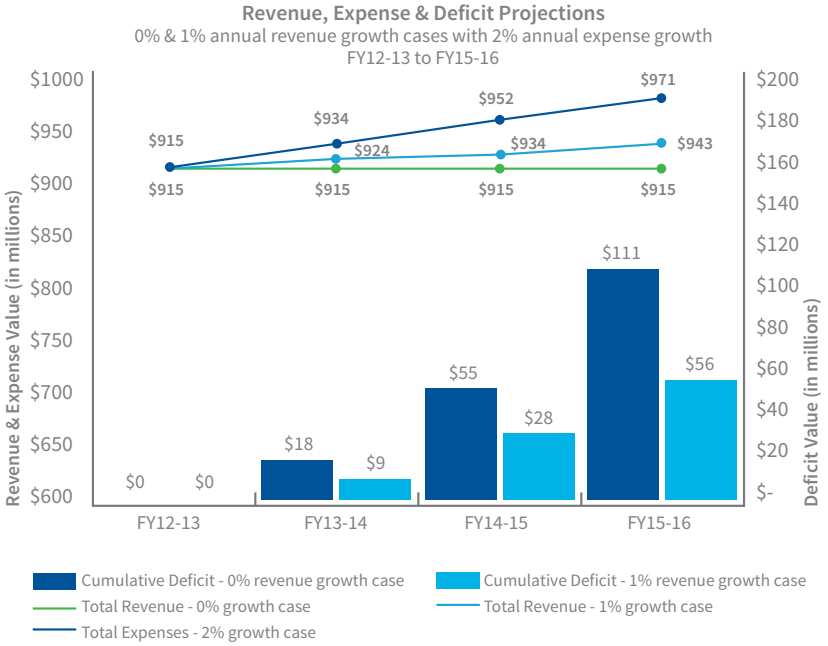
What We Have Heard:

- Wait times in the emergency department are too long
- Many patients do not have a family physician
- Patients have to wait too long to move to a long-term care home or other community home
- Our growing community needs access to health care close to home

Our population is growing and needs are increasing. At the same time, health care spending has flat-lined. To continue to provide high quality care in a challenging fiscal environment, we need to evolve our care delivery models to create new efficiencies. With our provincial gross domestic product (GDP) growth currently below 2% and expected to rise slowly, and the province in a major deficit position, changes across all sectors are required to reduce spending. For hospitals, that means that the previous annual increases averaging 6.1% will now be 0-2% [7]. This will further challenge the ability of health care organizations to provide the same level of services and balance their budgets. In 2010-11 alone, one in four hospitals reported a deficit.[8]

Our organization is one of the most efficient hospitals in the province, with a low cost per weighted case. Our efficient operations contributed to reported surpluses in the recent past. However, with the anticipated growth in clinical activity combined with announced reductions in annual funding, our hospital is projected to be in a significant deficit position by 2015-16 unless we begin to do things differently. To continue to meet our growing community's needs, fundamental changes are required now.





Compounding our service challenges is a real health human resources pressure. Our region has fewer physicians, particularly family physicians and specialists, per capita than many other parts of the province [6]. Primary care physicians also operate more often in solo practice than in organized, team-based care, which limits the ability to achieve system-wide coordination. Our dedicated nurses are also aging, with 30% eligible for retirement within the next five years [1].

KEY FACTS:

- 1 in 3 people in our community are not enrolled with a family physician [6]
- Family physician and specialist supply in our region is significantly lower than in Ontario overall, by 40% and 19% respectively [9]
- 30% of nurses and 50% of our management staff are eligible to retire in next 5 years [1]
- Canadians (60%) are more likely to use EDs for conditions that could be treated by primary care when compared internationally (47%), and are the highest users of EDs [10]

Our community's limited access to primary care is one of the factors contributing to pressures within the hospital. Because a large proportion of residents do not have a regular primary care provider, they rely on sporadic care through emergency departments (ED), urgent care centres (UCC) or walk-in clinics for health issues that could have been managed outside the hospital. This increased and unnecessary demand on hospital services is particularly pronounced in our EDs, which are operating over capacity. At one site, our ED is working at 156% over capacity [6]. If current trends continue, visits to the ED will increase by 50% by 2024 [7].

Our region also has the fewest long-term care (LTC) beds, 6.68 per 100 people over the age of 75, as compared to the Ontario average. This is a decrease from two years ago, when we had 7.22 beds –the lowest ratio of all regions at that time [11]. This constraint leads to pressure on hospital services, as people who are waiting for appropriate care in a long-term care home become too frail or ill to remain at home.

OUR CHALLENGE: A DISCONNECTED SYSTEM

What We Have Heard:

- It is complicated and difficult to know where to go for health care services– for patients, their families and providers
- Teams of health care providers need to work together, with the patient's needs in mind
- The right kind of support is not in place to keep people well in and outside the hospital

Our organization is focused on delivering hospital care to those with acute health care needs, while other non-hospital services, such as long-term care, community care and primary care have developed separately to meet other patient needs. This has resulted in a complex system where care is delivered by many different providers who are often disconnected. This leaves the burden on patients to integrate their own care and share information with their providers.

This lack of connectivity between the many providers who deliver care to our community creates challenges, not only for patients but for providers as well. Our patients and providers experience a fragmented system with long waits, which can be confusing to navigate and is costly to maintain. For example, as patients move from primary care, through hospital care, to rehabilitation, community care or long-term care, multiple records may be created and the same tests may be ordered by multiple providers, creating a fragmentation in the patient's medical history. This not only creates duplication across the system, but more importantly can create risks for patient safety and increases the burden on patients.

Health Care System Profile in Our Community

77 different health care providers in the region are separately accountable to the provincial government and regional bodies

17% of Ontario hospital bed days are used to support patients waiting for a more appropriate level of care

1 in 8 patients in our hospital are readmitted to the within 30 days of discharge

264 primary care physicians (30%) in our region are caring for patients in a solo-practice model

60% of family practices and 80% of specialists in our community do not use an electronic medical records

Our Approach to Addressing Challenges to Date

In the past, we have addressed our challenges via two key strategies: focusing on continuous quality improvement to achieve the most efficient delivery of services and generating additional revenue.

Over the last five years, we have worked hard to drive quality and efficiency in order to deliver exceptional care to our community. In total, savings and efficiencies of $47.5 million have been achieved in order to address gaps between our growth in revenues and growth in patient volumes [14]. These efforts have resulted in our hospital delivering the highest ranking quality of care at the lowest cost.

While these strategies are foundational to our hospital, they will not be enough to sustain the highest quality of care for our community. The challenges we now face will require a fundamental change in our thinking and how we deliver care. Our vision for the future and priorities set out in this document define how we will continue to address our challenges in a more effective way to deliver exceptional services to our community.

Trillium Health Partners Highlights

Facilities
- 1,200+ beds
- 3 hospital sites
- 3 million square feet

Budget
- $915 million annually

People
- 8,000 + employees
- 1,200 + physicians
- 2,000 + volunteers

Trillium Health Partners

Quality
- Recognized as a top performer by the Canadian Institute for Health Information

Patients
- Largest hospital providing acute care with 1.5 million visits
- 220,000 emergency and urgent care visits
- 52,000 inpatient discharges annually

Our Vision for a New Kind of Health Care

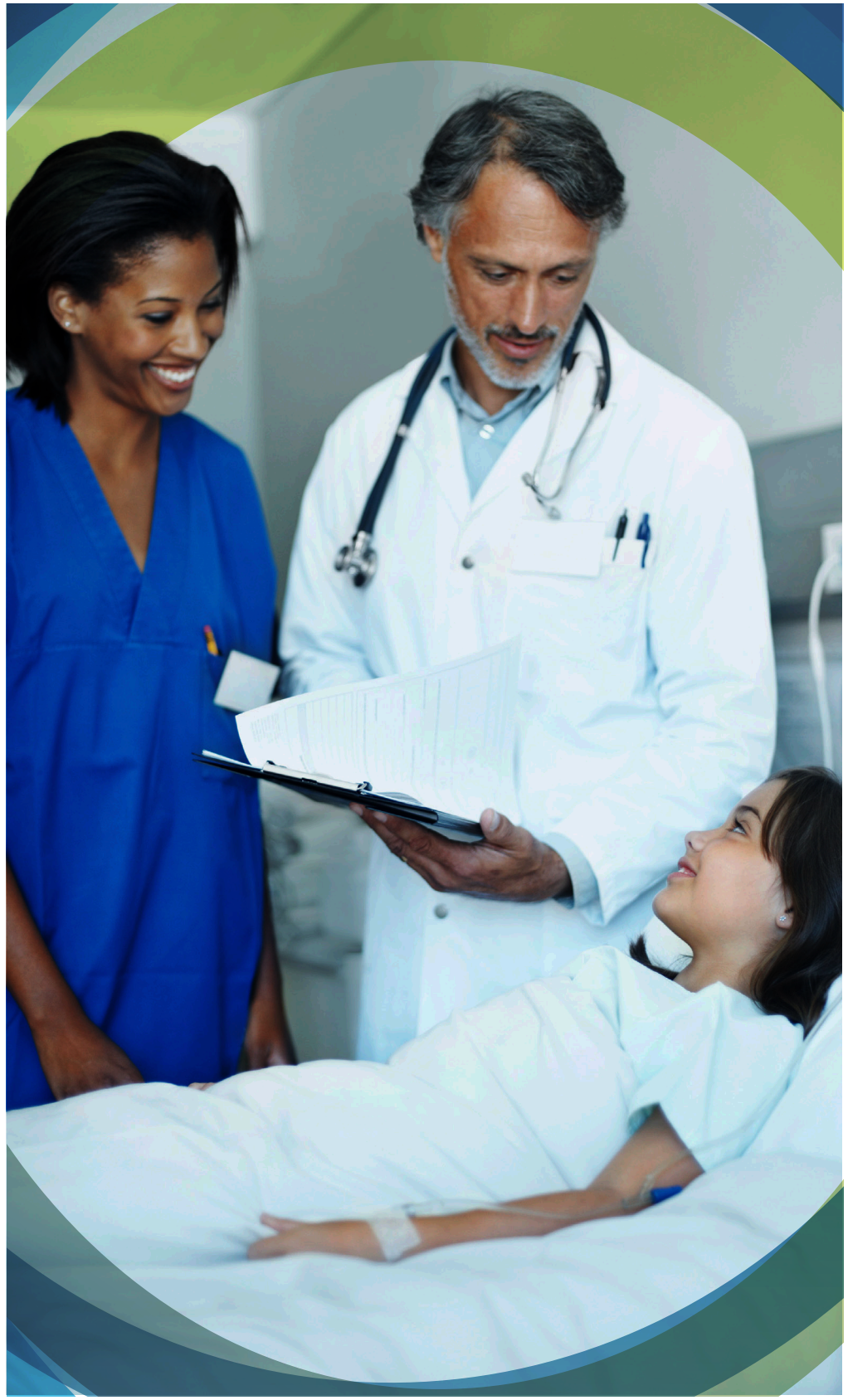
This is a plan to create a new kind of health care.

It was informed by the voice of our community and what they said is important to them. We engaged directly with over 23,000 patients, families, community members, staff, physicians and volunteers to understand their priorities and needs. What we heard is that our community needs us to think differently for better health. It is our mission, our reason. *A new kind of health care for a healthier community.* Our plan focuses on more than just treating people when they are sick – it focuses on what we all want and need: ***to be as healthy as we can be, at every stage of our lives.***

Our vision is to deliver the best possible health outcomes and an exceptional experience– for every person, every time - together with our partners. One health care organization working in isolation cannot make this happen. A new and unprecedented level of partnership is required to create a truly interconnected and complete system of care, with people at the center, and with *quality, access and sustainability* as foundations. We are ***Better Together***.

The most important partnerships will be the ones we develop with people in our community, engaging them as active participants in regaining and maintaining their health. To deliver the care and experience that our community has told us they need in order to stay healthy, we will need to think and act differently.

Our Strategic Plan sets out the framework for determining where we can take a leadership role in the health care system and where we can support our partners to take that role. By leading a systems approach to planning that considers all of the resources in our community, we can create better connections among health care providers, ultimately resulting in a complete system of care for people in our community. As we begin to live our strategy, we will be anchored by core values and beliefs that will guide our decision making and our actions as we create a new kind of health care for a healthier community.



Trillium Health Partners

Better Together

Our Strategic Plan

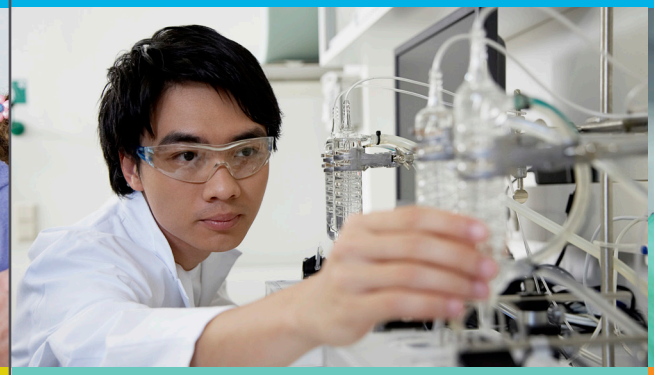
OUR MISSION

A new kind of health care for a healthier community

OUR BELIEFS

We believe in healthcare that works for you

We believe in active participation of patients and families



We believe in quality and innovation

We believe in the power of teamwork

OUR GOALS

Quality • Access • Sustainability

OUR PRIORITIES

Highest Quality Care, Exceptional Experience • Right Care, Right Place, Right Time • Research, Innovation & Education

OUR VALUES

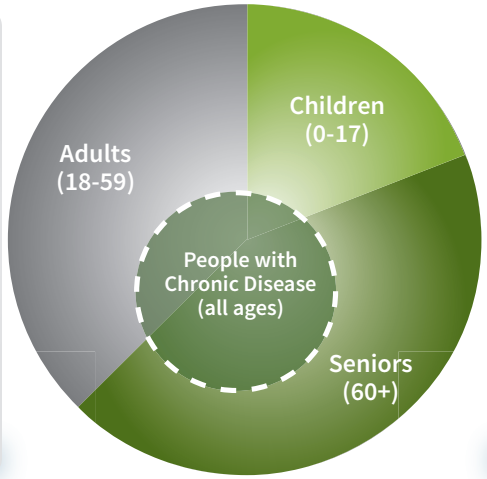
Compassion • Excellence • Courage

Making an Impact on Those Who Need it Most

Every day, we serve a large and diverse group of people, each with unique needs. To make the greatest possible impact and create a healthier community, we need to think differently about how services are designed and delivered for our community, particularly for those people who use the hospital most often.

While many people, approximately 30% of our patient population, use hospital services to get emergency care, specific surgery and other acute interventions as necessary, a large proportion of our patient population requires our services on an ongoing basis to address complex or chronic care needs. This means that many patients come to the hospital multiple times throughout the course of a year to get the care they need – and often, the hospital is only one of the health care providers that interacts with the patient. In our region, the populations that account for 70% of the hospital's volumes and resource utilization are children, seniors and people with chronic diseases. These people most often require ongoing care, either in hospital or in the community.

30% of our patients represent adults who do not have a chronic disease and typically require acute / episodic interventions.



70% of our patients are people of all ages with chronic disease and will benefit most from a managed and coordinated system of care.

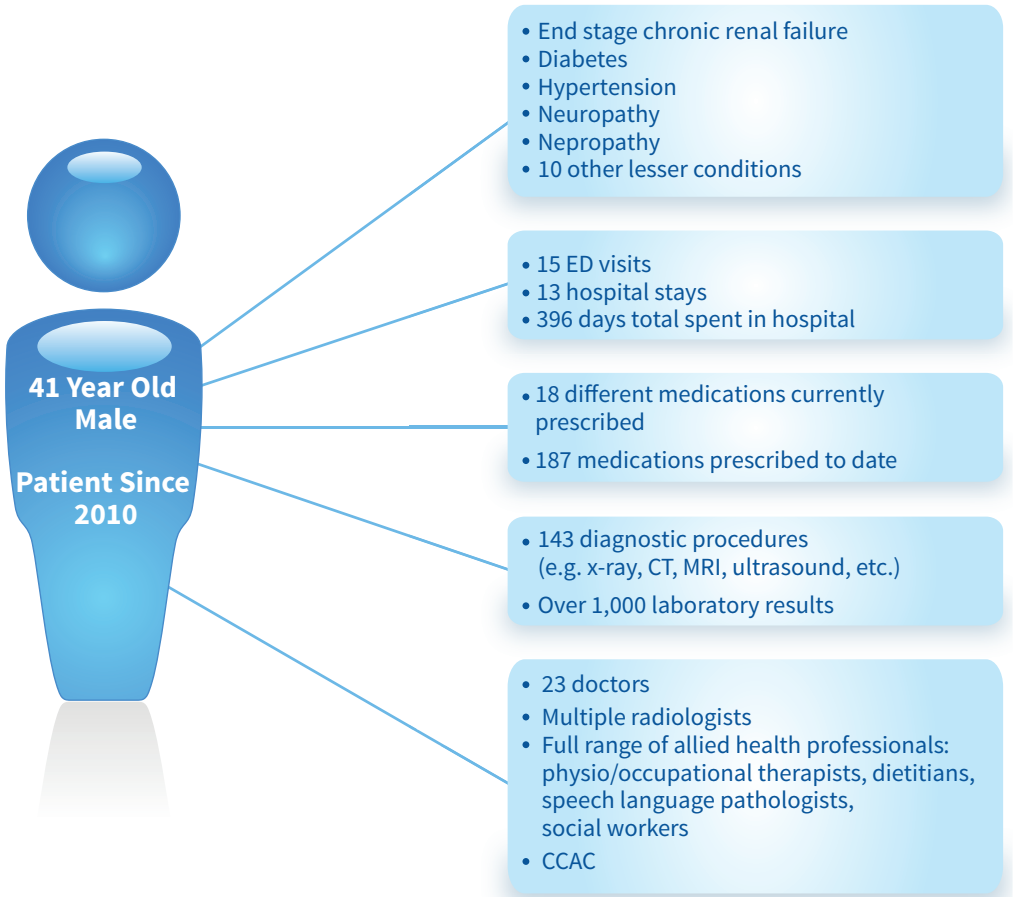
Through our engagement of thousands of patients, families, staff, physicians, volunteers and the broader community, we heard that for people who interact with the system most often, as well as the providers caring for them, the system needs to change. Children, seniors and people with chronic disease require ongoing and often complex care that may involve multiple providers inside and outside of the hospital to deliver the necessary care. They told us that health care can be complicated and difficult to navigate and that they are missing the critical supports they need to be healthy. Change is imperative if a meaningful difference is to be made for these growing populations.

Through leadership, better planning and coordination, we can create a system that works for every person, every time. By understanding our patient populations and their unique needs, we can design and deliver services in a way that will make the most impact on our community. By addressing the needs of people proactively and in collaboration with our partners, we can make better use of our system's resources. Ultimately, better care for those with the greatest needs is the path to ensuring a sustainable system for all people.

PEOPLE WITH CHRONIC DISEASE

As a result of medical advances and the shift of how chronic diseases are categorized, more people than ever before are living with complex illnesses and chronic diseases, like heart disease, diabetes, asthma, mental illness and cancer. They require coordinated care from multiple providers, everything from coordination of appointments, to information sharing between providers, to home monitoring and support to keep up with the regimen of medication, diet and exercise they need to maintain their health.

Today's Reality for People with Chronic Disease



While only 10% of patients are admitted to hospital directly for a chronic disease condition, this does not account for patients admitted to hospital for an acute condition with a chronic co-morbidity [13]. Further, patients with chronic disease consume more resources on average than other patients, particularly among the senior population, and are at a higher risk of readmission to hospital following discharge.

Chronic Disease Profile in Our Hospital [15]:

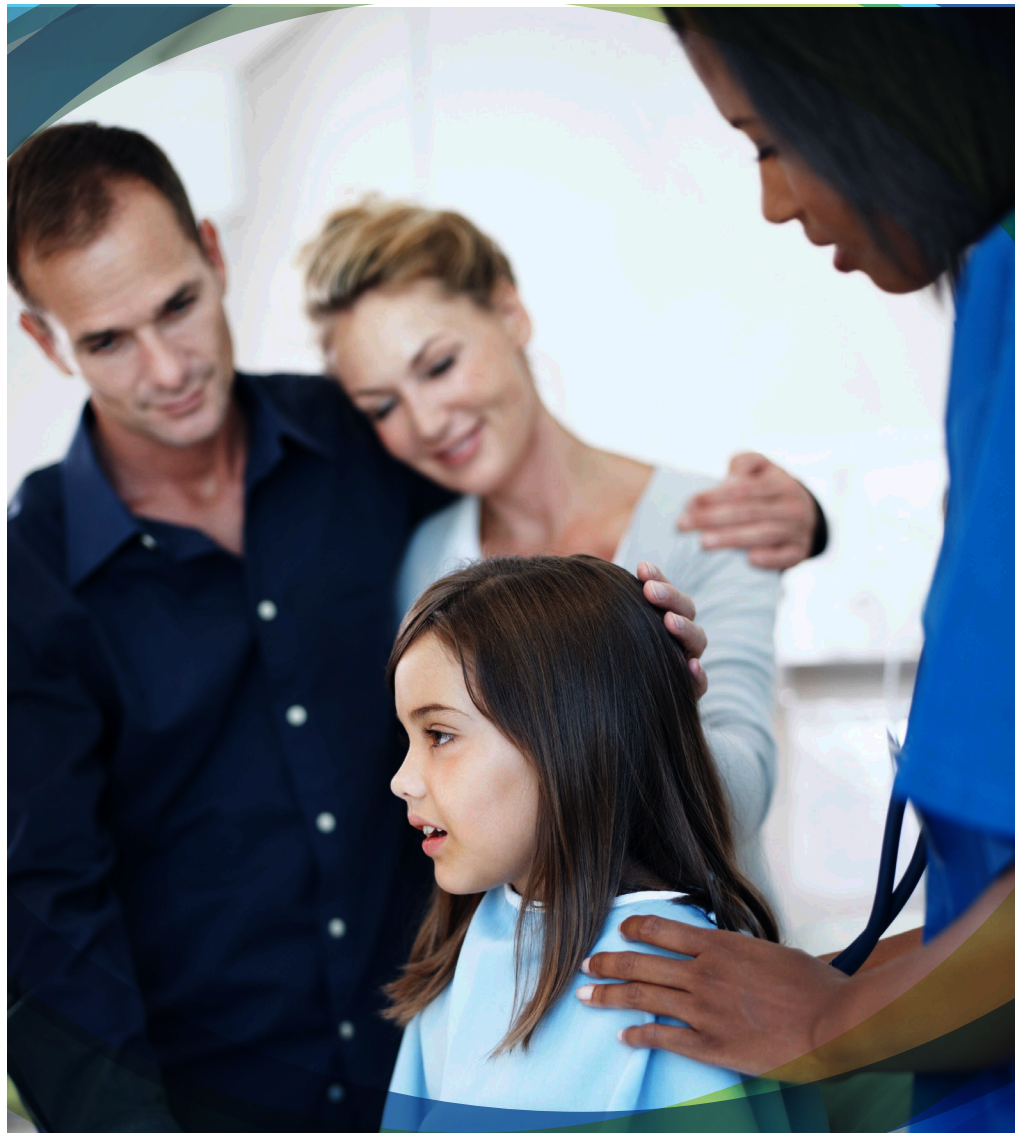
- Children (0-18 years): asthma, diabetes and cancer
- Adults (19 – 59): angina, heart failure and cancer
- Seniors (60 +): heart failure, angina, cancer

Seventy-nine percent of deaths in Ontario are attributable to chronic disease, many of which are due to cancer and cardiovascular disease [5]. Chronic diseases also account for 33% of all direct health care costs in Canada [15], in patients of all ages. Further, single chronic conditions often contribute to the development of other chronic conditions and illnesses. For example, those with diabetes account for 32% of heart attacks, 43% of heart failures, 30% of strokes, 51% of new dialysis and 70% of amputations in Ontario [15].

Mental health care, which traditionally includes disorders such as anxiety, depression, psychoses and substance abuse, is a specific component of the chronic disease spectrum that requires special attention as we plan for the future. In Ontario, these services are largely disconnected and spread across sectors, creating an ineffective system for those who require treatment. Patients and their families struggle to navigate the system, especially at points of transition, such as from hospital to outpatient care. The stigma of mental illness has led to isolation and made it difficult to monitor patients, particularly those with concurrent illness such as substance abuse. To more effectively plan for and manage the provision of mental health services, new models of service delivery are required. The importance of new strategies for the care of mental health disorders is underscored by data that identify it as the second leading cause of disability and premature death among Canadians [16]. One in five will experience an episode of mental illness during their lifetime, 70% of which will occur during childhood or adolescence [16]. For a high level overview of the future of mental health care delivery, please see appendix IV.

Prevention, effective management and self management are key contributors to reducing the number of people who require hospital care and ensuring patients with chronic disease get the care they need from appropriate community providers on an ongoing basis. By engaging patients and their families in their care and sharing accountability for health outcomes with those living with chronic disease, we can maximize health care resources to care for those who are not able to care for themselves. This will also enable people to regain their independence and lead healthier lives.

CHILDREN & FAMILIES



Early investment in children's health can greatly improve long term health and well-being. Failure to do so may be more detrimental in this population given the impact on lifelong health. We have an opportunity to deliver better health outcomes for children in our community by being leaders in the integration of services across sectors and between levels of care. We will also empower families with the information, tools and support they need to partner with us in providing care that is best practice. Support for families and caretakers is an important consideration when planning for children's care, as many of these patients are too young to care for themselves or make decisions regarding management of their care.

Children under the age of 19 comprise 25 percent of our region's population. It is projected that this number will grow by 50% by 2035 [2]. Within the hospital, we have a large paediatric population, accounting for more than 50,000 ED visits, 8,000 births and 12,000 inpatient admissions annually [13]. Further, many paediatric patients from our community are currently treated outside of our region, as they require more specialized care. Over a three-year period, between 2007/08 and 2009/10, there was a steady increase in paediatric patients from the Mississauga Halton LHIN receiving care at The Hospital for Sick Children and at McMaster Children's Hospital.

The table below provides an overview of patients who received care at The Hospital for Sick Children.

Patient Type	2007/08	2008/09	2009/10	Top 3 Reasons for Visit
Inpatient Cases	1,540	1,643	4,446	General paediatrics, haematology / oncology and orthopaedic surgery
Clinic / Daycare Visits	22,735	24,323	26,626	Surgical: Dentistry, ophthalmology, urology Ambulatory: Oncology, dentistry, orthopaedics
ED Visits	4,043	4,043	4,900	Canadian Triage and Acuity Scale (CTAS) 3, 4 and 5

Source: Maternal Newborn Child and Youth Regional Program Clinical Integration Project, Final Report, March 1, 2011

Based on this information, it is clear that we have an opportunity to provide care for these patients closer to home. Partnerships with hospitals and providers who deliver services to our residents will enable this to happen more quickly.

The landscape of children's illness is changing. While hospitalizations for injuries and acute conditions have decreased, 10 – 15% of children have a chronic illness such as asthma or diabetes. More than 25% of Canadian children are overweight or obese, increasing the risk for hypertension, heart disease and diabetes. Advances in medical care have resulted in greatly improved survival for children with serious conditions such as cancer, cardiac, metabolic and genetic disorders. Assistive reproduction advances have resulted in a greater number of low birth weight and premature infants.

The 1% of children who are medically complex account for 34% of paediatric health care costs. The highest 1% of spending in acute care in Ontario includes children with cancer, low- birth weight premature infants and those requiring technological interventions. [17]

The mental and physical health of children is often closely inter-related. Anxiety, depression and eating disorders are among the mental health conditions that affect almost 15% of Canadian children at any time. Individuals who experience an episode of major depressive disorder during their teenage years are at a two-fold increased risk of depression as adults, and a four-fold increased risk of attempting suicide. According to the World Health Organization (WHO), depression will be the single largest medical burden faced globally by 2020. By focusing on caring for children, we can reduce the burden of illness faced now and in the future. Better outcomes are achieved when illnesses are identified and treated early in life, which in turn reduces the burden of more severe illness later in adulthood.

Partnering with and empowering parents and caretakers to help manage their child's condition can enable care to be effectively provided at home, and help avoid hospitalizations. For instance, one of the most common diseases in paediatric populations is asthma [13], which, unmanaged, can create a significant burden on the patient and the health care system, particularly through preventable ED visits.

SENIORS

Seniors rely on health care more than anyone else in our community. They require support to help manage age-onset diseases and frailty. For all seniors, patient safety is a particular consideration as evidence suggests that seniors are at a two-fold increased risk of experiencing an adverse event while in hospital, and are at an increased risk of readmission to hospital after discharge [3].

This population often also has very complex care needs, which become more difficult to manage as they age. Frail seniors in particular have unique needs, with one in three experiencing a loss of independent function following a hospital stay. Sadly, half of these individuals are not able to recover this function following discharge [3]. Those who require an alternate level of care after a hospital stay can wait months to be placed in a home or facility. To keep seniors as healthy as possible during a hospital stay, and enable them to remain at home for as long as possible, we need an acute care system designed to meet their needs and integrated community and primary care supports to manage their health at home.

Seniors are the fastest growing population in our region. Those over 60 years of age account for 11% of our region's population and it is projected that this number will grow 175% by 2035 [2]. The unprecedented growth of this population will create unique challenges for health care organizations in the future as they try to manage the complex needs of individuals as they age.

Within our hospital, 37% of our total patient population consists of seniors [13]. This group also consumes 63% more resources than the average adult patient and accounts for 95% of alternate level of care (ALC) days in the hospital [13]. The story is the same across Canada, where 83% of patients in hospital who are waiting for a more appropriate level of care are seniors [18]. This is not only a disservice to these patients; it also creates challenges for flow across the system – challenges that will worsen without action as the baby boomers age. These factors combine to make seniors the greatest consumers of our services. By designing a system that cares for seniors appropriately, we can keep this population as healthy as possible, so that they can receive care outside of the acute care system for as long as possible.

Achieving Our Vision of a Complete System of Care

In order to achieve our vision and effectively address our challenges across the health care system, we will be guided by our continuous efforts to improve quality, accessibility and sustainability of the care we deliver to our community. We will need to focus on delivering excellent quality care within the hospital and take on a new leadership role to create system-wide change for a healthier community.

Quality, Access and Sustainability

Quality, access and sustainability are foundational goals of our Strategic Plan, and core drivers of our success. These strategic goals anchor our efforts and everything we do at our hospital. We are continuously guided by our desire to achieve the highest quality of care that is easily accessible for our community, at the lowest cost.

While we have performed well in each of these areas in the past, new thinking is required to maintain or improve delivery of services. We will achieve this in two ways: by focusing on excellence in the delivery of high quality hospital care and by working with our partners to together better meet the growing needs of our community. Our Strategic Plan leverages our success from the past and continues to advance our goals within the hospital's walls and with our partners.

Excellence in the Delivery of High Quality Hospital Care

We deliver high quality, efficient hospital care to thousands of patients every year. A number of past initiatives have improved quality and access while also reducing costs. These initiatives have resulted in our hospital becoming one of the highest performing hospitals in the country, as was most recently recognized in a report released by the Canadian Institute for Health Information (CIHI).

Our success to date has been driven by the collective aspirations of our people, who are committed to delivering exceptional care to patients each and every day. Across the organization, our staff and physicians have applied innovation to improve efficiency and ensure that the quality of care we deliver is exceptional, in the face of increased demand for service and more complex care needs.

We will continue to provide a comprehensive set of acute, rehab, complex and long-term care services to our community across our sites. We will relentlessly maintain our focus on continuous quality improvement in order to deliver world-leading hospital care to our community. We will deliver safe and efficient care for our patients, and look for the best ways to deliver the highest quality care at the lowest cost while improving the overall patient experience.

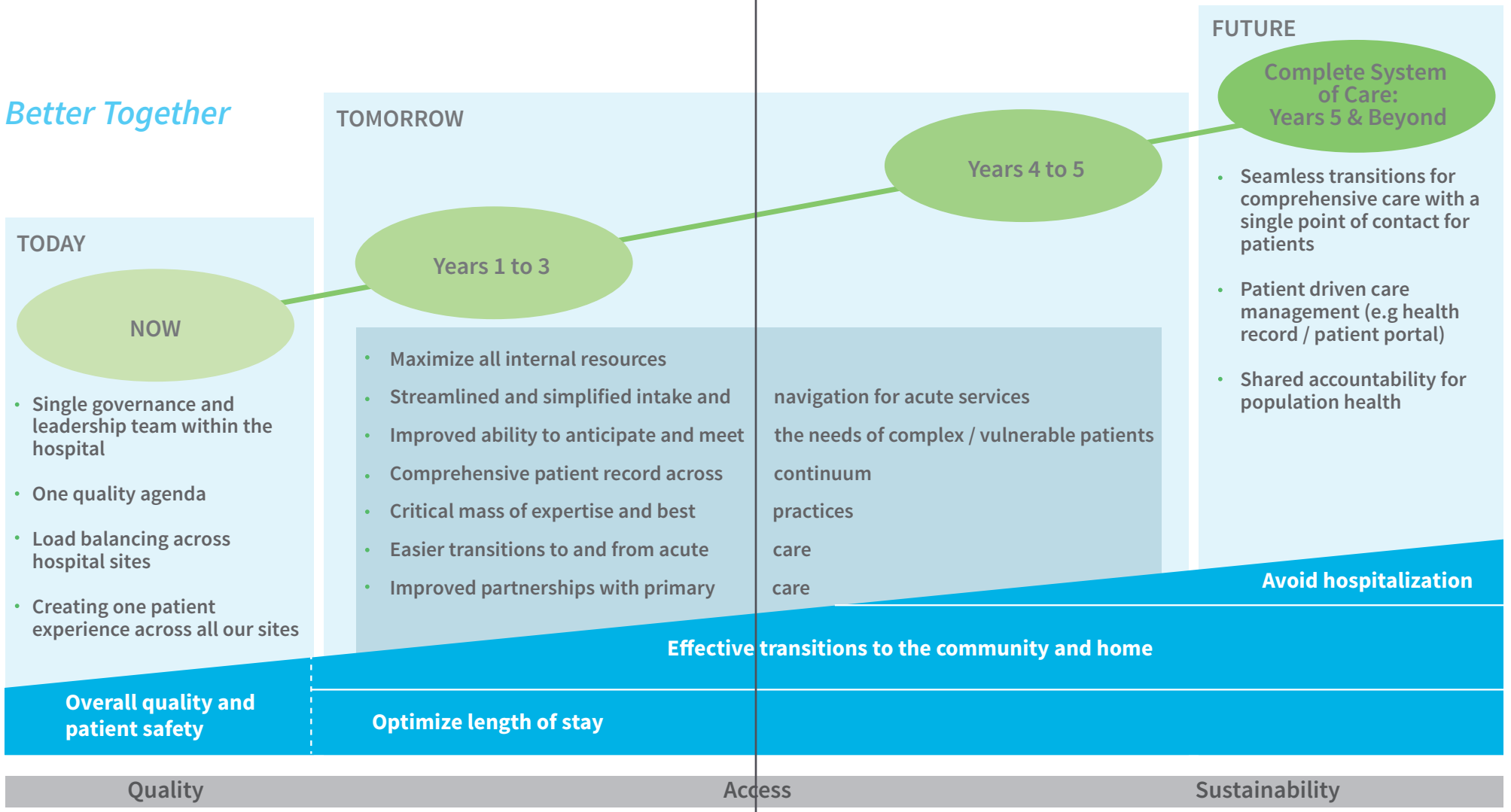
System-Wide Change for a Healthier Community

We know that our efforts have sustained high-quality hospital care amidst the pressures of the past and the present, but the future will require new thinking and action to address new challenges. When hospitals and community providers, such as family doctors, home care providers and long-term care work in isolation, people are left trying to navigate a complicated and disconnected system alone while trying to regain or maintain their health. Our hospital's emergency departments serve as the one place people know they can access a comprehensive suite of health care services in one place when they need it. In our community we know that more than ever before, people are relying on emergency departments for health care. Through partnerships with primary and community care, we can help address the dependency on emergency rooms by promoting early intervention, prevention and effective management of care outside of the hospital setting.

We have an opportunity to take a leadership role in advancing the partnerships required for better care coordination and delivery in the region. Through partnerships with other providers, such as primary care, community care and other hospitals and agencies, we will be able to create change together and improve the way we collectively serve our community.

We will dedicate our efforts to leading system-wide change so our community can benefit from a complete system of care. This vision will be achieved over time and will incrementally result in higher quality, connected services that lead to a healthier community.

Better Together



Our Strategic Priorities for the Next Five Years

To achieve our vision and deliver high quality, accessible and sustainable health care for patients, families, the community and providers, a set of strategic priorities define what we aim to accomplish over the coming years. These priorities focus on key areas that will enable us to create the most value for patients and yield the highest impact for an accessible, sustainable and high-quality health system.

The key to success for each of these priorities is partnership, with patients, their families and providers across the system. Our priorities will only be achieved by creating a truly interconnected system of care across the continuum that improves our collective ability to deliver exceptional care.

Better Together: Action Plan
Quality, Access & Sustainability

Strategic Priorities

Highest Quality Care, Exceptional Experience	Right Care, Right Place, Right Time	Research, Innovation & Education
• Leading Practice Delivery • Team-Based Care Models • Innovative Service Delivery • Nothing About Me, Without Me • Patient Designed Navigation • Children & Seniors Friendly Hospitals • Standardized Access & Flow	• Integrated Care Models for Chronic Diseases • Better Transitions • Primary & Community Care Partnerships • Strategic Information Supports	• Research & Innovation Strategy • Education Agenda

A Healthier Community

Optimized length of stay	Reduced waits and improved transitions to the most appropriate level of care	Reduced avoidable hospitalizations

Highest Quality Care, Exceptional Experience

LAUREN DONNELLY, patient

Diagnosed with leukemia at the age of 15, Lauren was referred to the Paediatric Oncology Group of Ontario's Paediatric Satellite Clinic at our Credit Valley Hospital site to receive most of her cancer treatment. Lauren's care was overseen by paediatricians in our hospital, with direction from her primary oncologists at The Hospital for Sick Children. It was comforting for Lauren and her family to know she would receive outstanding quality care close to home, and not have to spend precious time and energy commuting to Toronto. During the course of her treatment, Lauren's team of doctors and nurses worked closely together to make sure Lauren's care was coordinated and centered on her needs.

"My team was really invested in my care, and I always knew I was in good hands. Being in my own community made it less stressful for me and my family to get the care I needed to recover. I had a fantastic experience during my cancer treatment - all because of the people caring for me. I built relationships with my team and volunteers that will last a lifetime."

Highest Quality Care

Our community expects, and deserves, to receive the highest quality services at every point of care whether they require our services in an emergency; for a one-time test, treatment or surgery; or regularly due to a chronic disease, we will deliver an exceptional level of care. While we have historically been a high performer in quality, to meet the needs of tomorrow we must continually find new and innovative delivery models, adopt or create leading practices in all of the services we provide, and implement team-based care models.

We will also need to make choices about our role in the larger health care system, both in clinical and non-clinical settings. We will have to make decisions about what we, as a hospital, are best suited to provide, and where it is in the best interest of our patients to receive care through partnership.

As we assess the needs in our community that are currently unmet and define our place in the health care system, we will look for the most effective and affordable ways to provide care, either internally or through partnerships. Together, we will have an opportunity to align services to the most appropriate care settings and work in partnership with other providers to ensure a complete system of care is developed in the region.

We will ensure that in everything we do, quality is a core element. This will be enabled by our highly skilled and dedicated staff, physicians and volunteers who care for our patients and their families every day. Our efforts to recruit, train and retain the best health human resources will continue as we build our strong team within and beyond our walls.

Exceptional quality of care and patient safety are fundamental standards any health care organization should strive for. Through our Strategic Plan, new standards and different models of care will be advanced to enable more comprehensive, sustainable and safe services for our community. We will focus our efforts on opportunities that will enable us to have the greatest impact across the organization, and eventually beyond our walls with our partners. We will strive to achieve the highest quality of care by becoming leading practice in services we provide, implementing team-based care models and implementing new and innovative delivery models.

Highest Quality Care in Action

Through our Highest Quality Care strategic priority, we will look at potential approaches that can help us achieve our vision:

Strategic Direction	This will…	Areas of Focus	Desired Outcomes
Leading Practice Delivery for All Patients	• Track our progress through defined quality improvement metrics • Track quality performance across acute clinical services • Strive to achieve results better than or equal to 90% of our peers across all our quality indicators in clinical programs • Implement process improvements to help reduce waste and improve outcomes	• Service planning and improvement to achieve leading practice	• Increased number of people returning home after hospitalization • Achievement of Quality Improvement Plan metrics • Overall quality metrics
Team-Based Care Models	• Maximize scope of practice for health care professionals by leveraging the interprofessional team in delivering care • Deliver care by an integrated team of multidisciplinary health care professionals • Improve patient access and experience with providers • Enable greater systems-thinking by providers through seamless connectivity throughout the patient's care journey	• Interprofessional care models across the continuum	• Improved patient satisfaction • Increased % confidence in care / staying well • Improved overall quality of care • Improved retention rates
Innovative Service Delivery	• Leverage the new patient-based funding model priorities to drive alternate service delivery models in clinical areas • Advance innovative and new delivery methods for non-clinical services • Leverage learnings from other countries and industries, using public policy instruments	• Alignment with patient-based funding priorities • Optimize patient-based funding opportunities • Seek out opportunities for new delivery methods for non-clinical services, such as working with partners	• Lowered cost per weighted case • Reduced readmissions • Maximized revenue • Set leading benchmarks for quality based procedures

Exceptional Experience

We envision an experience in which patients and their families have what they need to stay well. In the event that they do need medical care, we want them to know exactly what to expect during their journey through the system. Our ultimate goal is to put the patient at the centre of the system, making the overall experience from admission to discharge, and through transitions into the community and home, more positive and convenient. The transformation required to realize this vision will incorporate all aspects of what we do as an organization.

Creating an exceptional experience for each and every member of our community who needs support to be healthy is our priority. Whether they receive treatment and support in the hospital or as a part of a more complex care plan that involves other providers, everyone expects to receive excellent service and care through the health care journey. People expect the care they receive to be personalized to their unique needs as consumers of health care.

Understanding Patient Needs

Thousands of patient needs statements were considered to develop this plan. To summarize, patients say they need:

- To feel like we are responding to their needs
- To feel in control of their health and be independent
- The process to be easier
- To have more coordinated and connected services, inside and outside of the hospital
- To better understand how they are being cared for

"I need you to help me stay well"

Our Patient Declaration of Values & Our Commitment to You

- Provide you with timely access to high quality care in a safe and comfortable environment
- Share meaningful information about your plan of care, so you can make informed decisions
- Involve you and those most important to you in your care
- Listen and respond to your needs in order to build a trusting relationship
- Care for you with respect, compassion and dignity

We have heard from our community and our patients about what they need from their health care system. They want health care that better meets their needs and is focused on keeping them healthy. They want to know how to prevent illness so that they can stay healthy. They want to receive the best care as fast as possible and want the process to be as simple as possible, no matter where or how they enter the system. They also want to understand what is happening to them and how they will be supported to get and stay well.

To deliver an exceptional experience with active participation of patients and families will require a shift in the traditional patient-provider relationship. Communication that empowers patients and makes them a central part of the care team is essential. To do this, the needs of a diverse population, with people across the age spectrum, must be considered. As a health care delivery organization, we must be prepared to act on what patients tell us they need to make their personal health journey easier. This will mean changing structures, services, processes, practices, and how we think and behave.

We have a long history of driving change initiatives to support a patient experience and will draw upon our knowledge and past work to deliver transformation. More importantly, we will work with our partners in the community to build this change. We know that for patients, the good work of individual providers is often overshadowed by a system of care that is not coordinated or standardized. Providers across the health care continuum must work together to create an exceptional experience.

Patients and their families are our main priority and it is critical that their experiences at every point in their health care journey be positive and ultimately result in a healthier community. This attention to an exceptional experience transcends our organization and carries through to our partners, through seamless transitions and coordination of care. In an environment of shared-decision making with patients, it is possible to help empower them so that they can feel more in control of their care. This model of shared decision-making will drive better outcomes, improve satisfaction with services and ensure that people feel their care is responsive to their needs.

To advance our vision for an exceptional experience, we will design a system for our community that is easier to access, simpler to navigate, addresses unique needs and engages patients and their families in every aspect of their care. Together, these elements will create a more positive and convenient experience.

Exceptional Experience in Action

Through our Exceptional Experience strategic priority, we will look at potential approaches that can help us achieve our vision:

Strategic Direction	This will…	Areas of Focus	Desired Outcomes
Nothing About Me, Without Me	• Create a framework and supports for patients to be active participants in their care • Give patients and their families the confidence and information they need to better control the management of their health	• Framework and approach for *Nothing About Me, Without Me* program • Train staff and physicians to provide the necessary supports to patients and families	• Reduced readmissions • Reduced ED visits • Increased % of patients returning home after hospitalization • Improved patient satisfaction
Patient Designed Navigation	• Make way-finding within the hospital, and across all sites, easier for patients and their families • Enable smooth navigation for patients, families and providers through transitions across the health care system • Allow patients and their families to be aware of the steps in their journey through their care, whether within the walls of the hospital or beyond to other providers	• Patient transitions through the continuum of providers • Improved way-finding – within the hospital and outside	• Improved patient satisfaction • Improved employee and physician satisfaction
Children & Seniors Friendly Hospitals	• Create a seamless, personalized system for those patients who need us most – children and seniors • Help engage patients, families and care-takers in the care process by providing the necessary information about the care plan • Apply and develop best practice specialized approaches to care for geriatric and paediatric populations designed to keep them well	• Plans for children and frail elderly care and wellness • Self-management • Age appropriate care	• Improved functionality of seniors upon hospital discharge • Reduced hospital re-admissions • Reduced ED visits
Standardized Access & Flow	• Streamline referrals and access points to hospital services, making scheduling and appointment booking more convenient • Optimize patient flow across clinical programs	• Standardized patient flow and pathways across all sites • Wait list integration and management	• Reduced wait times • Improved patient satisfaction • Improved staff and physician satisfaction

Nothing About Me, Without Me

Better communication among patients, families and providers is central to creating an exceptional health care experience.

Nothing About Me, Without Me is a concept that originated in the United Kingdom, recognizing that each person has unique health care needs and goals and a unique experience. It is based on the belief that excellence can only be achieved when patients share in, and influence, decision-making in partnership with providers.

Evidence shows that involving patients in their care and treatment improves their health outcomes, boosts their satisfaction with services received, and increases not just their knowledge and understanding of their health status but also their adherence to a chosen treatment.

Right Care, Right Place, Right Time

VERNICE THOMAS AND URIAH THOMAS, daughter & patient

When Uriah was diagnosed with dementia and risk to injuries from falls, his daughter Vernice knew she would need to support her father. Uriah was referred to the Fall Prevention and Bone Health Program at Queensway Health Centre by his family physician and subsequently connected to a team of health care providers including a nurse, physiotherapist, pharmacist and a community centre program – all of whom worked as a team in providing care to Uriah. Together, Uriah's team has been able to manage his care outside of the hospital, primarily in his community or at clinics, with no inpatient admissions.

"One of the things that stood out for us is how seamless it was to receive care from all the different providers. They actually communicate with each other like a team. When we came in to see the doctor, she already had updates from the nurse, pharmacist and physiotherapist. We didn't have to update them on my father's care or progress. It was very impressive."

We envision a system where people in our community know how to get the care they need. We want our community to have faster access to care, easier transitions out of hospital and the highest quality of care. At the same time, providers will be enabled to deliver this care in the most efficient way possible. We envision a system where care for all patients, in particular vulnerable patients such as frail seniors or those with complex chronic diseases, is coordinated to provide treatment in the most effective way possible, by teams of health care professionals working seamlessly together inside and outside of the hospital.

Health care is delivered by a number of different providers, including primary care physicians, acute care hospitals, specialized hospitals, long-term care homes, public health and community health services providers. It is common for those requiring care to receive treatment from more than one provider and often the link between providers is fragmented, with few formal connections to support coordinated and efficient care. In our region alone, there are 77 health services providers all separately accountable to the provincial government and regional bodies, and over 870 primary care providers formed into multiple groups and solo practices serving the community. Each of these providers has its own governance, leadership, decision-making and business processes. That amounts to more than 900 potential access points for patients. While all partners in the region care for the same people and experience the same pressures, they operate in silos with little coordination.

The result is that many patients, who require simple treatment or long-term management of illness, are navigating a complicated system alone. These patients often end up accessing the most visible entry to the system: the emergency department. The ED is a popular choice for members of the community without access to a family doctor, because it is a reliable access point to reach a breadth of health care services all in one place, though it may not provide patients with the most appropriate level of care to meet their needs.

By taking a leadership role in system change and working with other providers, we can create a system that is designed around providing the best care where and when it is needed. Working together, we can simplify the system, enable coordination among providers and design services in a way that maximizes efficiencies, is easy to navigate and responds to the needs of patients.

All providers face clinical volume increases and financial pressures. Over the last several years, we have worked alongside the provincial government, regional bodies and partners in the region, including the Mississauga Halton Community Care Access Centre (CCAC) and community providers, on initiatives designed to better support patients, and provide them with the right kind of care at the right time. These efforts have been aimed at improving quality, access and sustainability of health care overall, and have led to a better understanding of patient needs and the partnerships that are required to meet them. Our Strategic Plan envisions taking that work to the next level, by focusing on efforts such as creation of integrated care models to achieve a complete system of care.

Understanding Integrated Care Models

Imagine that a patient with multiple care needs could access all the services they require to get well in one place. This reality is not so far away. An Integrated Care Model (ICM) is a managed approach to care that is accountable for meeting the health needs of its community [22]. Central to these models is a focus on improving health care delivery by simplifying transitions, delivering solutions for high-need patients and using fixed resources in the most efficient way possible. To be effective, these models bundle services across the patient's care experience – mainly from primary care to acute care, but also across long-term care, home care, and even pharmacy and laboratory services. These models are inherently flexible, so that they are designed according to local populations and have the ability to shift funding according to priority areas.

Successful ICMs exist internationally and the models are gaining prominence worldwide. In Ontario, St. Joseph's Health System Hamilton (SJHS) is already piloting a "bundled care model" for certain patient groups and Cancer Care Ontario (CCO) has also taken important steps along this path for cancer care and chronic kidney disease, designing a system that collaboratively manages care for these patients across the continuum, from prevention to palliation, with a regional focus.

The provincial government and regional bodies have identified integration and partnerships as a priority [19]. More specifically, an integrated and patient centred approach to care has been identified as a focus to deliver:

- Better supports to be healthier
- Improved access to services, specifically family health care (e.g. Focus on ED wait times)
- Appropriate and timely care at all levels, provided by the most appropriate provider(s)

Understanding the complexity of all the providers in the region, and coordinating care, we can bring providers together through integration to drive system-level sustainability and efficiency. Our Strategic Plan sets out the future direction for our organization, in alignment with those of the province and regional bodies.

Right Care, Right Place, Right Time in Action

Through our Right Care, Right Place, Right Time strategic priority, we will look at potential approaches that can help us achieve our vision:

Strategic Direction	This will…	Areas of Focus	Desired Outcomes

Integrated Care Models for Chronic Diseases	• Create value for patients and the organization by establishing complete, end-to-end care that is designed around patient needs
	• Enable better management of disease by connecting the patient's providers and delivering care in a coordinated environment
	• Align ambulatory care programs to best meet patient needs
	• Ensure standardized leading practice
	• Establish gateways for patients with chronic disease to enter the system and utilize services in a highly coordinated way
		• Integrated care models for the most burdensome chronic diseases:
		  • Cancer
		  • Diabetes
		  • CKD
		  • Cardiovascular Disease
		  • Mental Health
		  • COPD
		  • Asthma
		• Ambulatory care programs review and alignment
			• Reduced hospital re-admissions
			• Reduced ED visits for chronic diseases
			• Reduced admission rates from LTC

Better Transitions	• Allow patients with complex medical and social needs to be effectively transitioned out of hospital to home, where they will be cared for by a multidisciplinary case management team • Focus on patients with the highest risk of re-admission, based on a risk assessment during the acute portion of their stay • Create coordinated transitions for patients from hospital to long-term care by leveraging strong linkages with the CCAC and other community providers	• High-risk populations for avoidable admission or re-admission • New concepts such as virtual wards, in established priority areas	• Reduced hospital re-admissions • Reduced ED visits

While we can make improvements within the hospital to help advance our vision, we will not be able to fully realize the potential of integrated care without our partners. An unprecedented level of partnership will be required in order to create a complete system of care that is inter-connected and works for every patient, every time. We will create this system by building integrated care models, improving transitions of care, building strong partnerships and leveraging the best technologies to enable better information management and information sharing.

Continued from previous page:

Strategic Direction	This will…	Areas of Focus	Desired Outcomes
Primary & Community Care Partnerships	• Create strong linkages with primary care, public health, CCAC and community health services providers • Enable seamless patient management across the continuum of care	• Primary care network(s) to enable seamless patient management • Establish CCAC and other community partnerships to enable seamless transitions out of hospital and reduce hospital visits • Formalize partnerships and decision-making	• Reduced hospital admissions • Reduced hospital re-admissions • Reduced ED visits • Increased % of patients attached to a primary care provider • Reduced time to see primary care provider after discharge • Reduced ALC days
Strategic Information Supports	• Enable better and more consistent information sharing between providers within the organization and with other providers • Enable streamlined decision making and a reduction in duplication of patient information • Create more comprehensive information sources for research, trending and decision-making • Enable greater patient engagement through self management and technology • Improve efficiency, quality and safety of services through streamlined systems and information management	• Integration of I&IT within the organization to create one platform between sites • Regional integration of hospitals through a common patient health record • Patient portals and online tools to enable patients to manage their care via technology and have access to their records	• Improved efficiency of service delivery • Improved quality of care • Improved patient safety • Reduced medication errors • Increased patient satisfaction • Increased provider satisfaction

Research, Innovation & Education

NADIA SALVO, medical student

Passionate about pursuing a career in medicine, Nadia chose the Mississauga Academy of Medicine for her education because it was close to her home. The program opened in 2011, and Nadia is among the first class of 54 medical students to be trained right in our community. Nadia has had the opportunity to learn in an intimate setting and interact with patients, physicians and other health care professionals.

“Being one of the first students at the Mississauga Academy of Medicine is an exciting opportunity. Learning in a smaller community, alongside other health care professionals, allows me to get practical experience in a more intimate setting with exceptional teachers. I am exposed to a wide array of cases that will help build my foundations in medicine.”

Research & Innovation

Building on our history of delivering front-line innovations to improve patient care, we will be dedicated to building a portfolio of research and innovation that focuses on system change for better outcomes.

Our opportunity in research and innovation will be to bridge the gaps and improve the complete process of care for people, resulting in the delivery of better outcomes. We will not focus on becoming a highly specialized or research intensive hospital driven by scientific discovery. Instead, we will focus on health system planning, integration, organization and evaluation, and on innovations that bring enhanced care to the bedside.

In partnership with our patients, their families and providers, problems will be identified with current health practices and a case for change to the system will be developed. Solutions and innovations to address these problems will be tested, to gain an understanding of the barriers we currently face and the structures necessary to implement change on a larger scale. Following an evaluation and validation of the innovation, if appropriate, it will be incrementally rolled out across a larger spectrum to maximize impact on outcomes. Finally, the solution will be transferred into practice and shared with other providers for system-wide transformation. The value of this practical and collaborative approach will be innovative research that creates real outcomes for patients through practice in a dynamic clinical environment. This approach will also create an organizational agility that will allow us to grow as we learn through health systems improvement.

Our focus on practical, applied research and innovation will enable the testing and utilization of new processes and technologies that are designed to improve patient care and outcomes. Dramatic advancements in technology will be one of our greatest challenges, however we can leverage our research, innovation and education agendas to better serve our patients in the long-term. We can become a catalyst for new innovations through proven and tested methods that yield the best outcomes for our patients and community.

Our focus will be on improving the health and wellbeing of our community by building and acting on a formal research and innovation agenda. This agenda will create a living lab of innovation, where new methods of care are tested and evaluated in a real-practice environment, and where innovation for the patient is lived and breathed across the organization, reducing the time from innovation to practice.

Research & Innovation in Action

Through our Research & Innovation strategic priority, we will look at potential approaches that can help us achieve our vision:

Strategic Direction	This will…	Areas of Focus	Desired Outcomes
Develop a Research & Innovation Strategy	• Set a vision for research and innovation • Define the way in which research and innovation will support our strategy and drive better outcomes for patients	• Health system planning • Integration • Organization • Evaluation • Innovation	• Fully implemented research and innovation strategy

Education

We are committed to investing in the education and cultivation of expertise by providing training and development opportunities for the 8,000 of our staff who require continuous learning. We believe in the power of teamwork, so we will create an environment where professionals continuously learn from each other and collaborate effectively to care for a diverse population of patients. Evidence shows that health systems are strengthened and improved care is delivered when professionals work together in teams [19]. Teamwork is essential to preventing errors and protecting patient safety. And it is widely accepted that health care workers who learn together will work better together in their future professional careers. Interprofessional education is therefore one of the key components of our overall education agenda.

Interprofessional education teaches health professionals how to collaborate and practice together. Given the complex needs of many of today's patients, a team may include nurses, physiotherapists, occupational therapists, pharmacists, speech-language pathologists, physicians, attendants, nurse practitioners, respiratory therapists and social workers. Interprofessional education begins with creating role clarity and understanding of each profession's contribution to the care of patients along the continuum.

Our new academic mandate gives us the opportunity to advance learning and teaching in team-based care.

In 2011/12, we trained the first cohort of 54 medical trainees from the University of Toronto at Mississauga. Each year, an additional 54 trainees will join the program. By 2014/15, we will train 216 medical students, and by 2020, an estimated 302 post-graduate medical learners will be residents at our organization [20]. Annually, there are over 1,800 nursing students and over 200 allied health students engaged in pre-qualification training [21].

With the introduction of the medical learner to the organization, we can proactively create new learning opportunities to advance interprofessional care. Over time, it is envisioned that interprofessional education will move beyond the walls of hospitals and be integrated with primary and community care to create a truly system-wide, interprofessional model.

Education in Action

In the first year of delivering on our Strategic Plan, we will work closely with UTM-MAM and other key partners to establish an interprofessional education agenda that can be integrated into practice in the subsequent years.

Strategic Direction	This will…	Areas of Focus	Desired Outcomes
Develop an Education Agenda	• Set a vision and framework for education across the organization, for all staff and providers • Set a vision and framework for team-based, interprofessional education and care models • Create an interprofessional teaching agenda that embeds in the training of all disciplines that work in a health care environment the approach of working together as a team as effectively as possible • Define how we can optimize our affiliation with UTM-MAM • Define requirements and resource needs for an effective education and delivery framework	• Understanding and maximizing scope of services	• Fully implemented interprofessional education agenda • Improved staff and physician satisfaction

JONATHAN CAVA, nursing student

Having grown up in a family of nurses, Jonathan followed suit and pursued his nursing studies at Humber College. He wanted to know that each day he would be making a difference in people's lives. As a nursing student and extern at Trillium Health Partners, Jonathan receives practical, hands-on training from a dynamic team of health professionals. He has been able to apply what he learns and treat patients more independently, in real clinical settings, while still having the support of experienced faculty and professionals.

"Team work is important in providing holistic and quality care for our patients. As nurses, we can't provide all the care that patients need and working with physicians and other clinicians collaboratively is very important. We share our respective knowledge and work together to help our patients get better."

Living Our Strategy

Our People Will Enable the Strategy

We have a highly engaged team of staff, physicians and volunteers who have enabled the organization to become a top performer in the country. We currently have more than 11,000 people, including administrators, nurses, physicians, allied health professionals and students, who serve our community by contributing their invaluable skills and dedication each and every day. Our success in achieving our vision and our strategy will rely on the strength, courage, expertise and diversity of our people, who are committed to delivering exceptional care to our patients. Our Strategic Plan embodies our people's aspirations to be leaders in making the health care system work even better for our patients, the community and providers.

A key priority for our organization will be to create the best environment for practice, learning and teaching. We will invest in making sure our people are well equipped in their roles and are able to provide the best possible care to our patients. We will continually refresh our focus on the recruitment, training and development of the most talented staff and health professionals, in order to build the strongest possible team and to become a beacon to attract new talent to our organization.

As we implement changes and face new challenges in the coming years, our people will focus on building and strengthening partnerships with other providers that will drive better outcomes for patients and create a more sustainable and accessible health care system. Each member of our team has a role in ensuring that we achieve our goals and deliver on our promise to our patients and their families. Whether taking part in direct care delivery, or supporting delivery through non-clinical services, every member of our team is essential to our success.

Our people are at the core of our organization and are members of our community. We will all work together to achieve our vision and create a new kind of health care.

The leadership of our Board of Directors and senior management team is critical in achieving the fundamental system change required to successfully deliver the strategy and meet our goals. Our leaders are accountable for implementing, monitoring and operationalizing our strategy, while our Board of Directors is accountable for providing guidance on strategic direction and priorities, as well as keeping leaders aligned to priorities. Collectively, they will facilitate the

development of relationships and advocate on behalf of our community to align resources in the manner most effective for improving the continuum of care for our community.

In addition to our people, there are key levers that will support our success that are central to the organization's operations. These levers are an integral part of the day-to-day delivery of exceptional care and will help drive the delivery of our Strategic Plan. We will focus on using our strengths in these areas, and further developing them, to create a seamless system of care focused on a healthier community.

Supporting Our Success

INFORMATION & INFORMATION TECHNOLOGY

Information and technology are key enablers of our strategy. To support effective operations, decision-making and strategy, it is essential to have systems in place to manage information about our patients, providers and operations. As we advance our partnerships in the community, information sharing between providers will become an essential component of exceptional care. This will require systems that share information with the patient and providers across the full continuum of care.

A number of benefits can be achieved through shared systems and information. Patients benefit by being more engaged in their care through consumer portals and mobile health technologies. Providers benefit by always having the right information accessible at all times and through the automation of critical functions such as medication order entry, patient referrals and discharge planning. The hospital benefits from improved operating efficiencies afforded by having common business processes and information supports across all points of service – both across hospital sites and external partners. To this end, the hospital is committed to developing and implementing new and merged systems in partnership with providers across the continuum of care.

Sharing common systems with our regional partners - the William Osler Health System, Halton Healthcare and Headwaters Health Centre - is foundational to our strategy. These systems will enable stronger partnerships, the smooth flow of patients and health information, provider collaboration and common performance measures. Planning for a Common Hospital Information System (HIS) is already underway in the region, and this is a significant move towards better information sharing between providers. We will leverage such opportunities to advance improved transitions and decision-making across the spectrum of care.

The benefits of common systems include:

Improved patient safety through the adoption of advanced clinical systems, including computerized physician order entry (CPOE), bedside medication verification (medication bar-coding), automated supports for physician decision-making

Safer, higher quality care and the ability of providers to embed evidence-based best practices into their work through common business practices

Improved patient engagement, through consumer portals and mobile health technologies, which enables patients to be active participants in their care

Common business processes, enabling greater economies of scale and a consistent, familiar experience for the patient

Shared information for improved decision making, enabling leaders to make consistent and effective decisions using common indicators and information standards

Streamlined laboratory, diagnostic imaging and pharmacy systems, enabling economies of scale and centres of excellence through the use of common testing, imaging work-ups and drug formularies

Increased mobility for staff and providers to do their work from any location using the same information and technology supports across the region

Economies of scale for technology hosting and development

Common interface for community physicians, governments and health authorities, enabling a single point of connection for a region encompassing 2 million patients

To realize these benefits, a significant investment in information management will be required throughout the course of our strategy. These investments will focus on two areas: integration of information across hospital sites, and electronic interaction with patients and community providers. By leveraging a shared systems approach, we can reduce cost and risk, while driving continuous quality improvement by monitoring and evaluating all that we do.

Measuring Our Success & Reaching Our Goals

As we put our Strategic Plan into action and bring it to life across the organization, it will be essential to continuously monitor and measure our progress. Through our Strategic Plan, we will focus our efforts for improvement on those who utilize health care services the most. This will have the greatest impact on achieving our desired outcomes and will help create a healthier community.

We believe that the three most important outcomes through our Strategic Plan are:

01 Delivering the highest quality of care and an exceptional experience to give people what they need regain and maintain their health

Optimizing hospital length of stay and providing the highest quality of care during hospital stay. Ensuring more people return home after hospitalization.

02 Ensuring people receive care from the most appropriate provider in the most appropriate setting faster

Reducing waits and improving transitions to the most appropriate level of care.

03 Keeping people out of hospital when they don't need to be here

Reducing avoidable admissions and re-admissions to the hospital.

In order to stay on track, we have to ensure the appropriate mechanisms are in place to tell us if we are making progress and if new approaches are required to achieve our vision.

Our Quality Improvement Plan (QIP) will serve as our foundational framework for measuring our organizational performance and the success of our strategy. It sets out our accountabilities for the delivery of high quality and efficient services which we strive each day to achieve. As we implement our Strategic Plan, the Quality Improvement Plan will continue to provide our framework for tracking operational progress, which can be supplemented by key targets and metrics that will be specific to our strategy. All of the metrics we will have in place going forward will contribute to understanding how we are doing against our desired outcomes.

Example indicators, based on our QIP, may include:

Quality Improvement Plan Dimension	Indicators
Safety	• Infection Rates • Hand Hygiene Compliance Rates • Pressure Ulcer Prevention • Surgical Safety Check List • Falls Prevention • Reduced Use of Physical Restraints
Access	• Emergency Room Wait Times • Cancer Surgery Wait Times • MRI & CT Wait Times
Effectiveness	• Hospital Standardized Mortality Ratio (HSMR) • Total Margin
Patient Centeredness	• Would You Recommend This Hospital • Overall Care Received
Integration	• Readmission Rates • Alternative Level of Care Days

By making choices that are guided by the direction set in our Strategic Plan, we will achieve the targets associated with our performance indicators. We will also work with our partners in the community to identify additional outcome measures that are representative of the system of care we will work together to build.

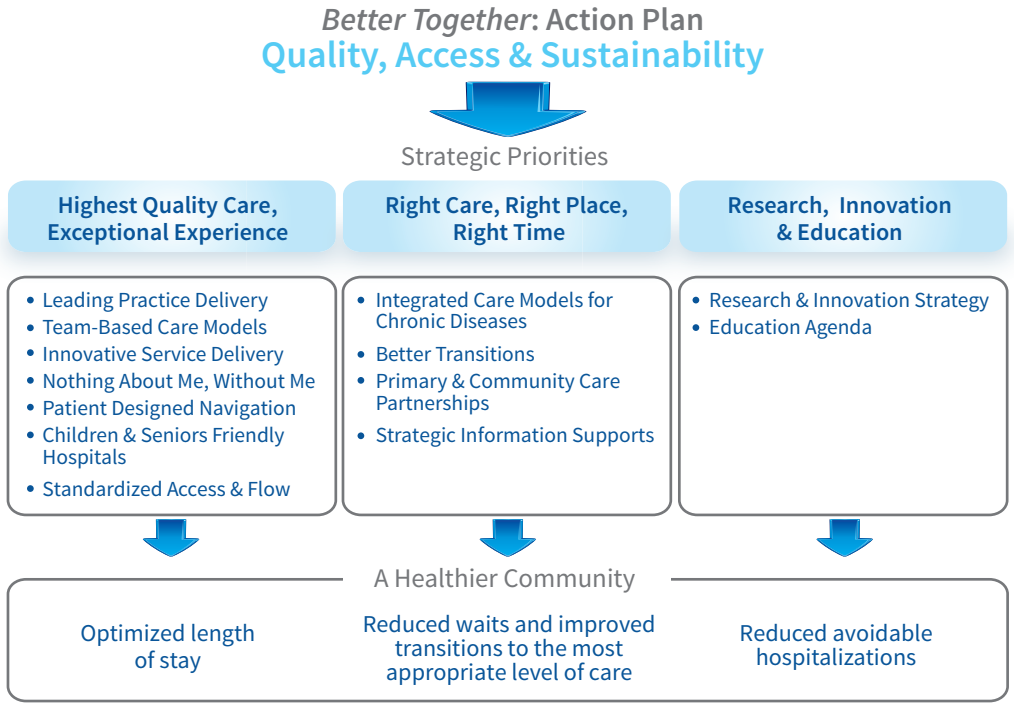
As a quality leader for our region, we will work with our partners to disseminate leading practices and standardized quality measures across the system, to provide our patients with an exceptional patient experience. We will also leverage the benefits of integrated quality practices to ensure that our system remains accessible and sustainable.

Conclusion

This is the founding Strategic Plan for our hospital and sets our vision for the next decade. It defines how we will build a new kind of health care for a healthier community and work in partnership with other providers to create a complete system of care in the region - for a better today, better tomorrow and better future.

We recognize that new thinking is required to effectively manage the challenges we face, not just within the hospital, but as a health care system as a whole. Our vision and our strategic priorities were defined to do just that – create new and innovative ways to approach health care, in order to deliver higher quality of care, and improve the accessibility and sustainability of services. At the core of our strategy is a new and unprecedented level of partnership with other providers in the community. We have to work together to achieve better outcomes for those we serve and to create a system that is more sustainable.

We will work with our partners, patients, families, providers and our community to achieve our vision. We will strive for the highest quality of care and an exceptional experience. We will ensure that those who require care receive it when needed, from the most appropriate provider. We will leverage our new academic and research mandates to drive better outcomes. We will do this by living our values and beliefs and continuously driving to achieve our vision –***Better Together.***



Appendix I – Quality Framework

As a public hospital, we continuously track, measure and monitor our progress in a number of key areas that help us make important decisions and stay accountable to government and the public. Our Strategic Plan is aligned with provincial and regional priorities, and we will continue to ensure we stay aligned as new priorities are set.

Ontario's Excellent Care for All Act (ECFAA), helps put patients first by strengthening the health care sector's organizational focus and accountability to deliver high quality patient care to patients. ECFAA has a number of key requirements of organizations, of which one is the development of an annual Quality Improvement Plan that sets out targets in pre-defined dimensions such as quality, safety and effectiveness. Since this legislation has been put in place, we have effectively tracked our performance against our targets, and aligned the QIP with our other planning processes across the organization.

We know that exceptional quality is not possible without key levers that drive and enable our performance. These levers include operational excellence, quality patient experience, research, innovation, education and our health professionals. Our strategy complements these levers with partnerships and relationships, public policy instruments, information and information technology and leadership.

Appendix II - Risk Management Framework

Risks to the strategy and mitigation tactics

Risks to executing the strategy must be mitigated. These risks – which are at both the individual priority and overall strategy level – must be tracked through their life cycle from the time they are first identified until they have been effectively mitigated. We will do so via a robust enterprise risk management framework that balances business, resource and compliance risks across the organization.

Enterprise Risk Management Framework
Risk Domains (Clinical & Corporate)

BUSINESS RISK Risks that may relate to the delivery of health care that include internal and external factors impacting on the operations of the department.	**RESOURCE RISK** Risks that relate to the resources used by the organization to accomplish its objectives.	**COMPLIANCE RISK** Risks that originate from the requirement to comply with a regulatory framework, policies, directives or legal agreements.
Quality Care, Access & Patient Safety	**Human Resources & Organizational Development**	**Environment, Health & Safety**
Clinical Quality and Infection Control Access and Wait Times ECFAA Critical Incidents	Labour Relations Talent Management Culture Total Rewards	Environmental Stewardship Cleaning and Maintenance Occupational Health & Safety
Corporate Governance	**Financial**	**Legal, Regulatory & Standards**
Governance	Operational Funding Working Capital	Legislation Compliance Regulatory Standards
Operations & Business Support	**Information, Systems & Technology**	**Policies**
Business Support Services Operational Partnerships	Infrastructure Data Integrity and Privacy Business Continuity	Policy Development Policy Compliance Policy Renewal Policy Education
Reputation & Public Image	**Physical Assets**	**Teaching, Innovation & Research**
Public Image Patient Satisfaction Media Exposure Government Relationships	Buildings Equipment Medical Devices	Research Clinical Trials Medical School Ethics

Risks to Delivering On Our Strategic Priorities

In addition to our comprehensive enterprise-wide risk management framework, the risks identified herein are inherent to the complex and dynamic nature of our strategy. They have been carefully considered in developing our Strategic Plan, so we could assess the practicality of implementing our strategy.

OVERARCHING RISKS

In assessing the risks in delivering on each of our strategic priorities, the following themes emerged as core risks that must be mitigated:

Culture and change management: Achieving our vision requires a significant paradigm shift across the health care continuum. There is a risk that current internal culture and communications do not support our strategic directions. With two strong existing cultures in the founding organizations, as well as an aggressive plan for changing long-ingrained culture and behaviours in health care, culture must be carefully cultivated and managed throughout implementation. Delivering the strategy will require an overall and comprehensive change management plan for achieving this transition. Clear accountability and responsibility for change management as part of overall strategy implementation and leadership structure will be required to ensure success.

Wide-scale and complex nature of proposed initiatives: The wide-scale and complex nature of the initiatives proposed in our Strategic Plan will present a number of risks to the organization, including its ability to absorb the change required to be successful while simultaneously maintaining excellence in operations. A carefully crafted sequencing plan must be created to mitigate this risk. This plan must ensure that the need for methodological sequencing, to build the required foundations for change, is balanced with the need to demonstrate early wins and successes, which will create and drive momentum for change. A strong plan that delivers clinical value to patients will be created to help balance these priorities and will be support by sound project and change management to mitigate the risks associated with scale and scope.

Policy infrastructure: Policy will be a key lever in creating incentives for both culture and behaviour changes. Policy must be used as a mechanism to foster innovation within the public system. In order to achieve the vision, the organization requires a policy environment that is flexible and adaptable to deal with constant change and create an efficiently administered system across the partnerships that will be built.

Expertise and competencies: The founding organizations bring together a wealth of expertise and competencies to support the delivery of our Strategic Plan. However, the degree of change proposed and the complexity of executing the organization's vision will require enhanced capabilities to be successful. This risk must be managed through a three-tiered approach of developing, coaching and building the capacities of internal staff; infusing external expertise into the organization to enhance the talent pool; and surrounding ourselves with advisors and expertise from our community and beyond, to support the organization's development.

Balance: The preliminary risk assessment reveals that in the near-term there will be a significant focus inside the organization on optimizing clinical care and building an exceptional patient experience. This will require a concerted effort to be successful. However, the long-term vision in our Strategic Plan requires that in the near-term we begin to build key partnerships. Balancing the internal focus on integration with the external needs to lay the foundation for the future is a key risk that must be mitigated through clear roles and responsibilities, to ensure that the senior team and Board of Directors have a balanced focus on these two priorities.

To ensure we deliver on our core objective of partnering to deliver exceptional care for a healthier community, these risks must be carefully managed throughout their lifecycle.

Appendix III - Strategic Decision-Making Framework

As we begin to implement our Strategic Plan, we will continuously align our work to our strategic priorities and make decisions that enable us to achieve our vision. Further assisting in this process will be a decision-making framework that helps identify potential areas of impact for our organization, our partners and our community. This framework is aligned with provincial and local priorities, as well as our Strategic Plan, and provides clear focus for the consideration of opportunities by the organization. We will have a wealth of opportunities to consider as we embark on the path to achieving our vision, and we must ensure that what we decide to do is in alignment with our Strategic Plan and that it will deliver on our desired outcomes.

Each decision we will make about our strategic priorities and initiatives going forward will be tested against our decision-making framework and desired outcomes. This process will ensure that we are pursuing opportunities that closely support our strategy and will ultimately deliver better outcomes for our patients. It will also ensure a fair and equitable process across the organization, with each program, service or department utilizing the same framework to support its decision-making. Further, decision-making will also be applied against the organization's ethical framework.

Traditionally in health care, decisions are made based on a single business model, without differentiating between the unique nature of programs within the hospital. To effectively make decisions and create the most value, it is important to understand the nature of each program. In general, there are three different types of business models that exist in health care [23]:

01 Solution Shop

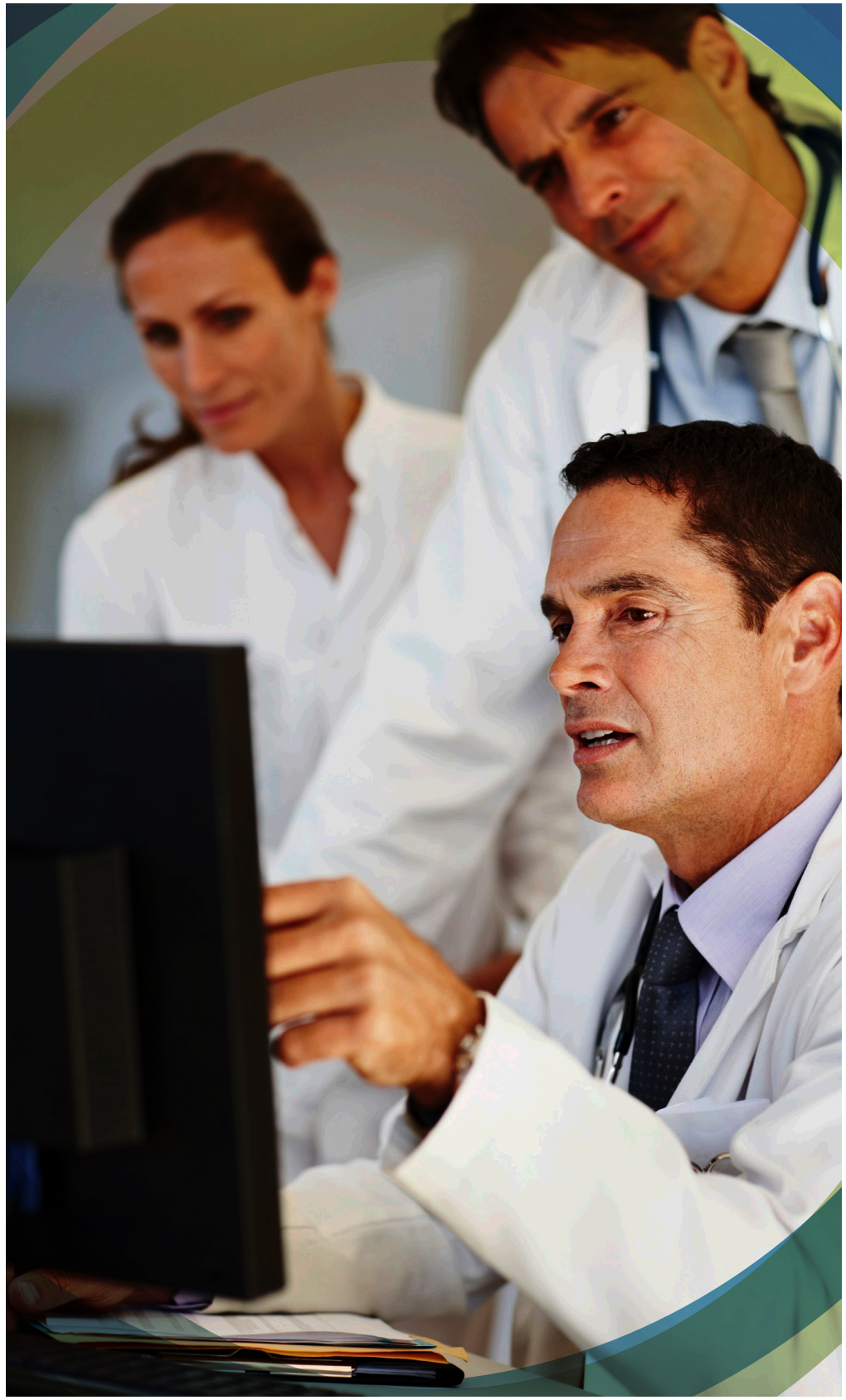
A fee for service model, these types of hospitals, programs or services are focused solution shops that practice intuitive medicine, where a continuous cycle of treatment based on hypothesis is practiced. Examples of solution shops include the Cleveland Clinic and Cancer Care Ontario.

02 Value Adding Process Business

A fee for outcome model, in which focused value-adding process hospitals, clinics and services provide procedures and treatment after definitive diagnosis. Examples of value adding process businesses include the Kensington Eye Institute and Sunnybrook Health Sciences Centre.

03 Facilitated User Network

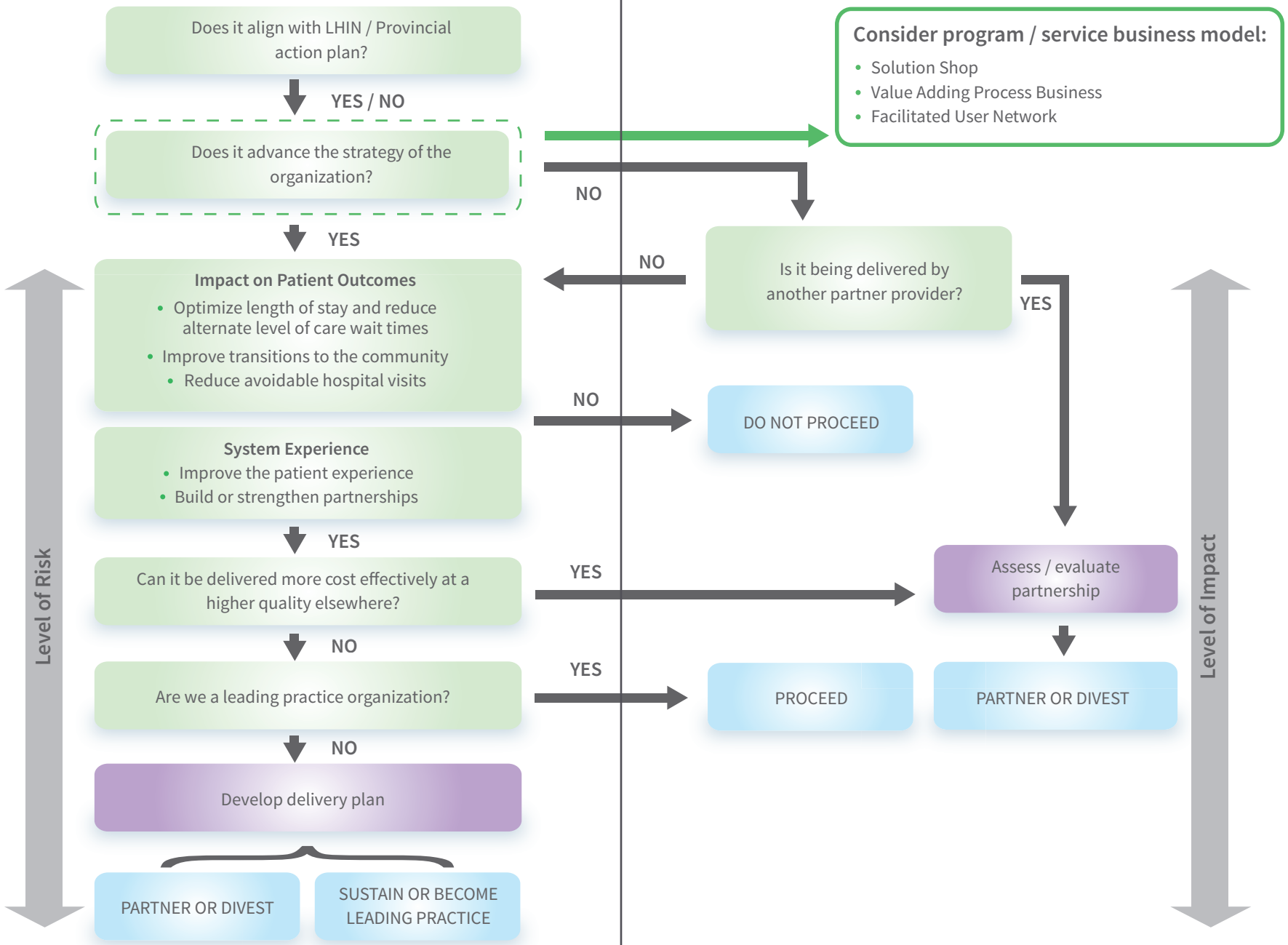
Facilitated networks primarily focus on connecting care in complex situation when multiple providers are involved. These types of hospitals, clinics and services play a dominant role in the care of many chronic diseases. Examples of facilitated user networks include the Mayo Clinic and Kaiser Permanente.



Once the Strategic Plan is launched in the organization, and each program, department and service initiates a service planning exercise, each will be asked to assess and identify itself with the most appropriate business model it is or should be.

We will be guided by a set of criteria that will allow us to define our focus:

Quality, Access & Sustainability



Appendix IV – The Future of Mental Health Care Delivery

Efforts to make our health care system more responsive and cost-effective, combined with fresh insights into chronic physical illness, are spurring design of new methods of delivering mental health services. They seek to expand the range of mental health care to include patients with physical and mental co-morbidities and to encourage professional teamwork, coordination of resources, and empowerment of patients. Interdisciplinary teams who will question current practices and design and implement better ones will form the cornerstone of the model. Mental health care traditionally includes disorders such as anxiety, depression, psychoses, and substance abuse. Under the new model, it will include the care of patients with medically unexplained conditions or chronic illnesses associated with mental health disorders that impair their ability to function. Medicine, mental health, primary care, and paediatrics will converge to provide state-of -the-art treatment for these patients across the lifespan. This pioneering work will reduce their suffering and lower spending on repeated hospitalizations, emergency room visits, and overcrowding of doctors' offices.

Under the model we envision, ways of managing chronic illness are expected to improve. Mental health co-morbidities that often accompany such illness or impede pain management can delay recovery. Along with interdisciplinary teams, use of the integrated care model for primary care physicians and subspecialists will help identify and manage mental health conditions and speed recovery from chronic illness. The most severe and recurrent disorders may be grouped to make patient care more coordinated and efficient. Team members will be supported in learning to identify mental health problems in their patients, who commonly seek their care before consulting a mental health provider. This model will target our most vulnerable populations, youth with chronic illnesses such as asthma, and seniors, especially those with cardiovascular disease and diabetes, both of whom are associated with morbidity and high use of health resources. This approach to care will be integrated into medical and nursing education at the University of Toronto.

Central to the model are programs that are recovery-based, placing less emphasis on "curing" patients than enabling them to recover. The Minister's Strategy for Mental Health and Addictions for Ontario for the next 10 years, as well as the Kirby Report, emphasize recovery as a fundamental value in delivery of mental health services. This approach encourages patients with a mental disorder to help form their own health care goals as team partners. It is an empowerment strategy that strengthens the patient's sense of control and often hastens recovery from physical illness. This focus on empowering patients is now part of the treatment strategy endorsed by provincial and local mental health leadership.

The importance of new strategies for the care of mental health disorders is underscored by data that identify it as the second leading cause of disability and premature death among Canadians [16]. One in five will experience a mental illness, 70% of them during childhood or adolescence [16]. The new model promises to correct the system's uncoordinated and fragmented aspects, address the variability in care based on location, and work on the access and navigation issues that have been repeatedly described by our patients and service providers. Integrating community-based mental health and addiction services with acute and tertiary care will reduce wait times for these services, which will – in turn – reduce the need for people to go to hospitals and emergency departments for care. Less demand on these facilities will shorten wait times for other patients seeking emergency care. We will measure our progress and further develop our programs in response to a continuing process of evaluation of outcomes.

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Notes:

Trillium Health Partners

Credit Valley Hospital

Mississauga Hospital

Queensway Health Centre

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