

Annual Business Plan 2017/18

Operationalizing Year 2 of the 2016-19 Integrated Health Service Plan (IHSP)



LIVING
HEALTHIER
AT HOME



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CONTEXT

Alignment with Provincial Mandate Letter for Health

The Premier's September 2016 Mandate Letter to the Minister of Health and Long-Term Care, the Honourable Dr. Eric Hoskins, outlined expectations for the health care system. The Central East LHIN acknowledges this direction and has aligned its 2017/18 Annual Business Plan (ABP) to activities that will contribute to the achievement of the Minister's mandate.

The Central East LHIN 2017/18 ABP activities will demonstrate leadership in supporting the successful implementation of the Patients First Action Plan and its four key goals:

- **Access:** Providing Timely Access to the Right Care
- **Connect:** Delivering Co-ordinated and Integrated Care in the Community and Closer to Home
- **Inform:** Providing Education, Information and Transparency to Support Informed Decision Making
- **Protect:** Making Decisions Based on Value and Quality to Sustain the Health Care System for Generations to Come

Central East LHIN 2016-19 Integrated Health Service Plan

The Central East LHIN's 2016-19 Integrated Health Service Plan is supporting the achievement of the LHIN's overarching goal of *Living Healthier at Home - Advancing integrated systems of care to help Central East LHIN residents live healthier at home* by:

1. Continuing to support frail older adults to live healthier at home by spending 20,000 fewer days in hospital and reducing Alternate Level of Care days for people age 75+ by 20% by 2019;
2. Continuing to improve the vascular health of people to live healthier at home by spending 6,000 fewer days in hospital and reducing hospital readmissions for vascular conditions by 11% by 2019;
3. Continuing to support people to achieve an optimal level of mental health and live healthier at home by spending 15,000 fewer days in hospital and reducing repeat unscheduled emergency department visits for reasons of mental health or addictions by 13% by 2019; and
4. Continuing to support palliative patients to die at home by choice and spend 15,000 fewer days in hospital by increasing the number of people discharged home with support by 17% by 2019.

Central East LHIN Mandate

This is a time of transition for Ontario's Local Health Integration Networks (LHINs) as LHINs and other partners embark on a multi-year journey to implement the *Patients First Act, 2016*.

As required by the Agencies and Appointments Directive, LHINs will be receiving mandate letters outlining service and performance expectations for the coming fiscal year. The Central East LHIN is committed to delivering on the mandate, once received, and will ensure that the following key pillars are maintained and strengthened:

- Promote health equity, and reduce health disparities and inequities
- Respect the diversity of communities in the planning, design, delivery and evaluation of services, including culturally safe care for Indigenous people and meeting the requirements of the French Language Services Act
- Continue to strengthen local engagement with Francophone and Indigenous communities
- Work with health service providers and communities to plan and deliver health services

How to read this Annual Business Plan

It is recognized that the transitional and transformation priorities set by the Minister of Health and Long-Term Care in the Mandate Letter are aspirational and will support meaningful improvements in health system performance and integration. Many of the priorities are aligned with and/or support the ongoing achievement of activities first articulated in the 2016/17 ABP, to support the attainment of the Central East LHIN's 2016-2019 Integrated Health Service Plan Strategic Aims.

Recognizing the evolution of transition and transformational activities, our ABP has been reformatted, highlighting prioritized activities that must be implemented in conjunction with the achievement of our overarching system Strategic Aims. These include:

- **Sub-region development** in which the LHIN, with input from partners and patients, will assess local population health needs, patient access and health provider capacity. Through the establishment and leadership of **sub-region planning tables**, LHIN funded and non-funded health service providers, primary care, public health, patients and caregivers, francophone and indigenous stakeholders, municipalities, social services providers and other partners will identify innovative and transformative actions, including advancing the **Health Links** approach to care, to further the LHIN's mission of creating an integrated sustainable health care system that ensures better health, better care and better value across the LHIN's seven sub-regions.
- **Primary Care alignment** in which the LHIN, through its Primary Care Physician Leads and its long standing Primary Health Care Advisory Group, will strengthen its relationships with primary care providers in each sub-region to achieve the pillars outlined in the Central East LHIN's Primary Care Strategy, October 2015.
- And, as accountability for the delivery of home and community care is transferred from the Central East Community Care Access Centre to the Central East LHIN, our overarching system Strategic Aims also includes **Home and Community Care**. Maintaining the continuity of patient care for individuals and families, including children, across the LHIN, while ensuring residents have access to equitable and quality home and community care services across the seven sub-regions.

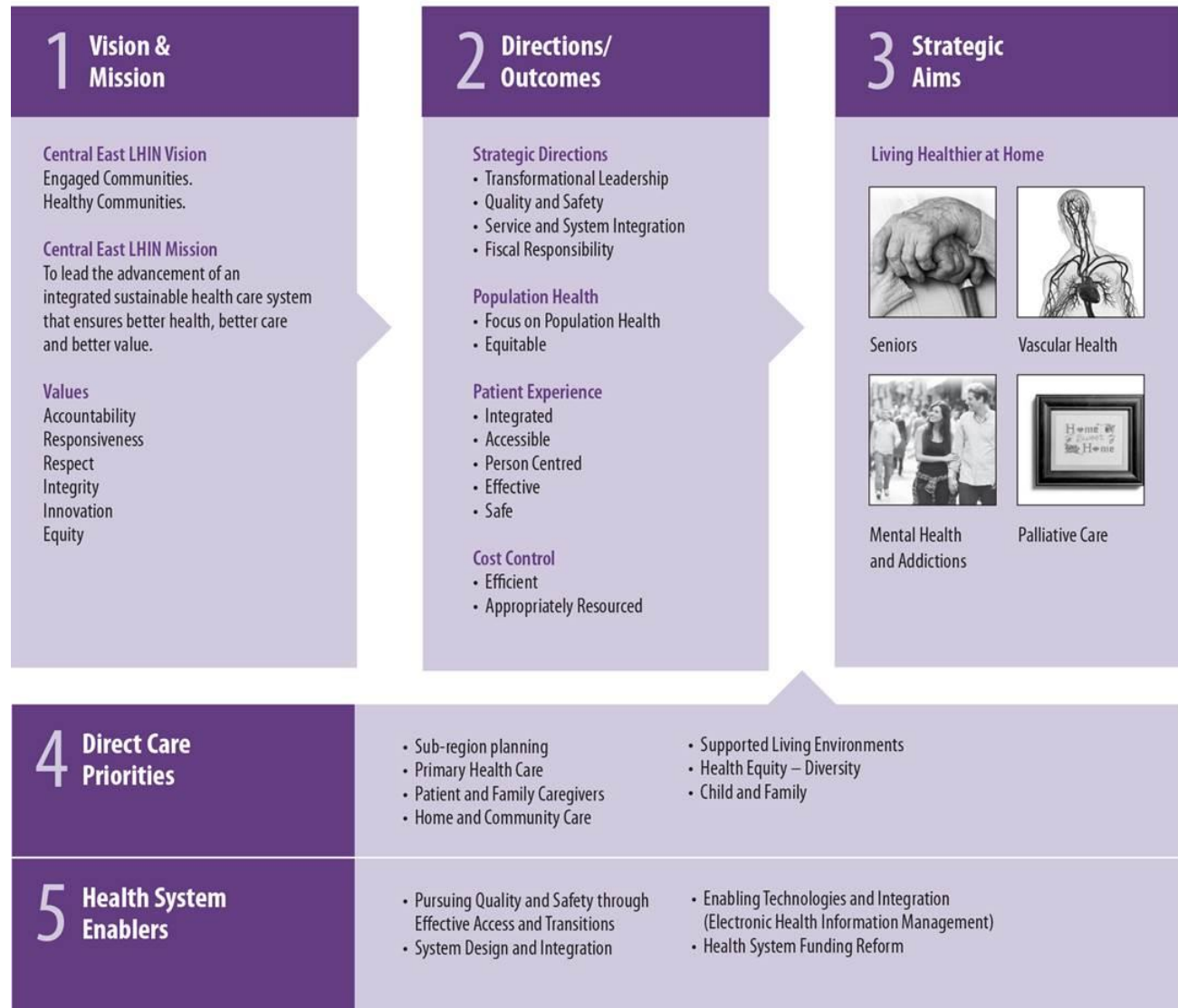
Central East LHIN Strategy Map

Since 2010, a Central East LHIN Strategy Map has provided the basis for Central East LHIN decision-making, bringing together the LHIN Vision and Mission with its Strategic Directions and Aims, the priorities and enablers.

Each year, the accomplishment of the LHIN's Strategic Aims and priorities is measured and evaluated through provincial metrics for LHINs (see Measuring What Matters: Performance Improvement, page 7). The Central East LHIN has continued to apply best practices in quality improvement through the application of the Institute for Healthcare Improvement's Triple Aim Framework (simultaneous pursuit of patient experience, population health and value for money) in our decision making and most recently, through leadership as an Institute for Healthcare Improvement Geographic Hub Lead for the 100 Million Healthier Lives campaign and by advancing Health Quality Ontario's Attributes of a High Performing Health System.

In the 2016/17 ABP, the Strategy Map was developed to guide the LHIN and its partners in their shared understanding of sequential elements to achieve the LHIN's Vision, Mission and Values.

This year, the LHINs and its partners will focus their efforts on those foundational Direct Care Priorities and System Enablers that are integral to the health system and ongoing achievement of the Integrated Health Service Plan (IHSP) Strategic Aims.



Measuring What Matters: Performance Improvement

Strategies and initiatives implemented in the Central East LHIN will be focused on achieving improvements of the 2017/18 MOHLTC/LHIN Accountability Agreement (MLAA) targets listed below. These targets are consistent across the province. In alignment with the expectation of the 2017/18 Mandate Letter, the Central East LHIN will continue to report on progress toward achieving health system performance targets, as well as the success of its transformational activities to Ministry and our local stakeholders.

Table 1: Performance Indicators <i>Definition: Measures of local health system performance for which a LHIN target will be set</i>		
Indicator	Provincial target	LHIN Target
Home and Community - Reduce wait time for home care (improve access) - More days at home (including end of life care)		
Percentage of Home Care Clients with Complex Needs who received their Personal Support Visit within 5 Days of the date that they were authorized for Personal Support Services	5 days	95%
Percentage of Home Care Clients who received their nursing visit within 5 days of the date they were authorized for Nursing Services	5 days	95%
90th Percentile Wait Time from community for Home-Care Services: Application from community setting to first Home Care service (excluding case management)*	21 days	21 days
90th Percentile Wait time from Hospital Discharge to Service Initiation for Home and Community Care**	TBD	TBD
System Integration and Access - Provide care in the most appropriate setting - Improve coordinated care - Reduce wait times (specialists, surgeries)		
90th Percentile Emergency Department (ED) Length of Stay for Complex Patients	8 hours	8hours
90th Percentile ED Length of Stay for Minor/Uncomplicated Patients	4 hours	4 hours
Percent of Priority 2, 3 and 4 Cases Completed Within Access Targets for Hip Replacement	Priority 2: 42 days Priority 3: 84 days Priority 4: 182 days	90%
Percent of Priority 2, 3 and 4 Cases Completed Within Access Target for Knee Replacement	Priority 2: 42 days Priority 3: 84 days Priority 4: 182 days	90%
Percentage of Alternate Level of Care (ALC) Days	9.46%	9.46%
ALC Rate	12.7%	12.7%

*The target is subject to change as a result of the ongoing work in the area of home and community care

**The target may be subject to change as it will be under development for the 2017/18 Fiscal year

Table 1: Performance Indicators		
<i>Definition: Measures of local health system performance for which a LHIN target will be set</i>		
Indicator	Provincial target	LHIN Target
Health and Wellness of Ontarians - Mental Health - Reduce any unnecessary health care provider visits - Improve coordination of care for mental health patients		
Repeat Unscheduled Emergency Visits within 30 days for Mental Health Conditions***	16.3%	16.3%
Repeat Unscheduled Emergency Visits within 30 days for Substance Abuse Conditions***	22.4%	22.4%
Sustainability and Quality - Improve patient satisfaction - Reduce unnecessary readmissions		
Readmissions within 30 days for Selected HIG Conditions	15.5%	15.5%

***The target is subject to change as a result of the ongoing work in the area of mental health and addictions

The LHIN will demonstrate progress towards achieving the LHIN's performance targets for the performance indicators set out in Table 1 to this Schedule by the end of the term of this agreement.

Table 2: Monitoring Indicators	
<i>Definition: Measures of local health system performance that the MOHLTC and the LHINs will monitor against provincial results or established provincial targets where set</i>	
Indicator	Provincial target
System Integration and Access - Provide care in the most appropriate setting - Improve coordinated care - Reduce wait times (specialists, surgeries)	
Percent of Priority 2, 3 and 4 Cases Completed Within Access Target for Cataract Surgery	Priority 2: 42 days Priority 3: 84 days Priority 4: 182 days
Percent of Priority 2 and 3 Cases Completed Within Access Target for MRI Scan	Priority 2: 2 days Priority 3: 2-10 days
Percent of Priority 2 and 3 Cases Completed Within Access Target for CT Scan	Priority 2: 2 days Priority 3: 2-10 days
Wait times from Application to Eligibility Determination for Long-Term Care Home Placement: From community setting, and from acute-care setting	Not applicable

Table 2: Monitoring Indicators

Definition: Measures of local health system performance that the MOHLTC and the LHINs will monitor against provincial results or established provincial targets where set

Indicator	Provincial target
Percent of Acute Care Patients who have had a follow-up with a physician within 7 days of discharge	Not applicable
Rate of emergency visits for conditions best managed elsewhere	Not applicable
Hospitalization rate for ambulatory care sensitive conditions	Not applicable

Table 3: Developmental Indicators

Definition: Measures of local health system performance that require development due to factors such as the need for methodological refinement, testing, consultation, or analysis of reliability, feasibility and/or data quality

Indicator
Home and Community Care • Reduce wait time for home care (improve access) • More days at home (including end of life care)
Percent of Palliative Care Patients discharged from hospital with home support
Sustainability and Quality • Improve patient satisfaction • Reduce unnecessary readmissions
Overall Satisfaction with Health Care in the Community

Sub-Regions

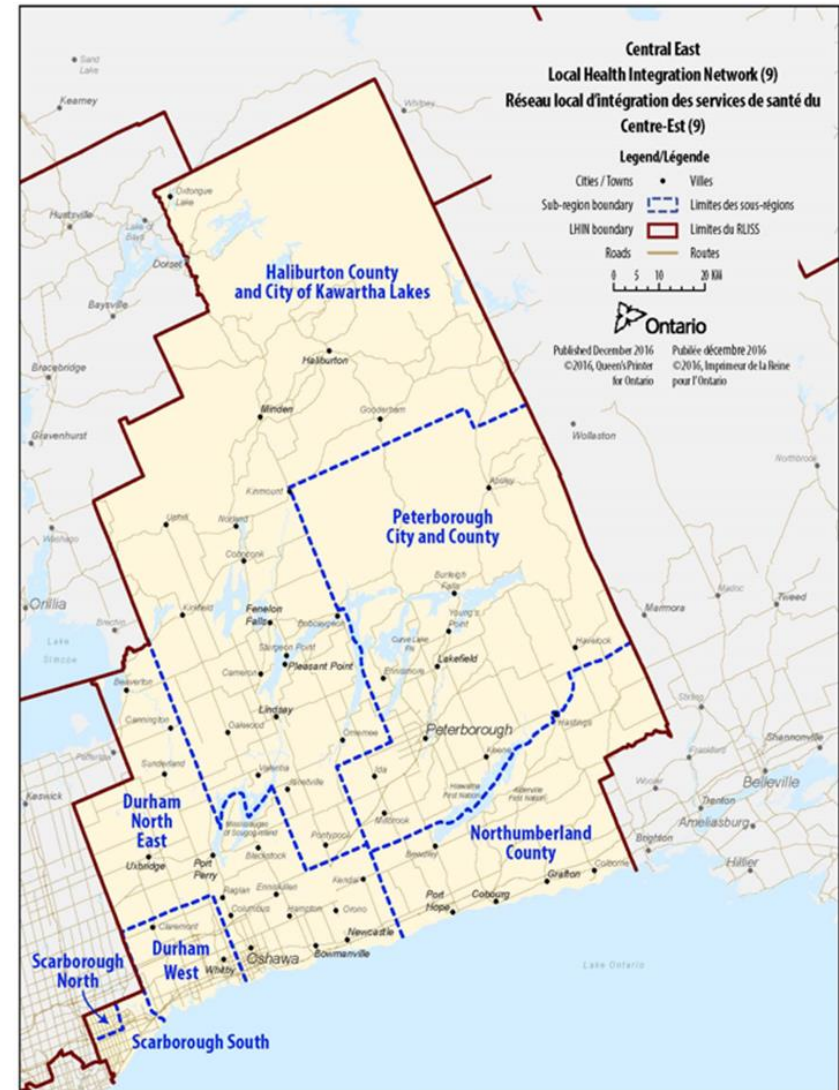
A sub-region is a smaller geographic planning region within the Central East LHIN that will help the LHIN to better understand and address population health needs at the local level. Sub-regions have been in place informally in the Central East LHIN for many years and they are now being formalized as a provincial planning approach for LHINs.

By looking at care patterns through a smaller, more local lens, the Central East LHIN will be able to better identify and respond to community needs and ensure that patients across the entire LHIN have access to the care they need, when and where they need it. This includes the needs of Francophone Ontarians, Indigenous communities, newcomers and other individuals and diverse groups within the Central East LHIN whose health care needs are unique and who often experience challenges accessing and navigating the health care system.

All seven LHIN sub-regions have been initiated in the Central East LHIN. These are:

- Scarborough South sub-region (population - 417,060)
- Scarborough North sub-region (population - 176,615)
- Durham West (population - 320,400)
- Durham North East (population - 287,800)
- Peterborough City-County (population - 134,920)
- Haliburton County and City of Kawartha Lakes (population - 90,260)
- Northumberland County (population - 71,200)

To support enhanced collaboration amongst health service providers and other stakeholders across the seven sub-regions, an environmental scan of demographics, population health, social determinants of health and health system information at the LHIN sub-region level has been developed to support decision-making. The environmental scan consists of eight chapters which describe the Central East LHIN and the seven LHIN sub-regions. See - <http://www.centraleastlhin.on.ca/resources/Publications.aspx>



OPERATIONALIZING THE ANNUAL BUSINESS PLAN

Sub-Region Development; Sub-Region Planning; Primary Care Alignment; Home and Community Care

During 2017/18, all efforts will be made to achieve the following prioritized action plans for sub-region development; sub-region planning (including the Health Links approach to care); primary care; and home and community care to further the Central East LHIN's mission of advancing an integrated sustainable health care system that ensures better health, better care and better value across the Central East LHIN's seven sub-regions.

Priority Description

Planning for the population needs at the sub-region level will be a key area of focus for 2017/18. This planning will engage LHIN funded and non-funded health service providers, primary care, public health, patients and caregivers, francophone and indigenous stakeholders, municipalities, social services providers and other partners to identify innovative and transformative actions, across the LHIN's seven sub-regions. This integrative planning allows for the opportunity to innovate care delivery and services to meet the needs of local residents.

Sub-region planning will continue to strengthen coordinated care delivery through the Health Links approach to care and primary care. Local planning will be supported through the establishment of sub-region planning tables. These tables will include patients and caregivers, clinical and administrative leaders across sectors to ensure a broad-based perspective informs and advises the Central East LHIN in health system planning and capacity building.

The three pillars of the Central East LHIN Primary Care (CEPC) Strategy will continue to provide an action oriented platform to guide primary care transformation activities namely, Leadership and Engagement; System Design and Reorganization; and Practice Level Improvements for Patients and Providers.

Home and Community Care services will continue to be provided within each of the sub-regions and opportunities to better coordinate services with primary care and ensure that the transitions of care that patients experience are seamless will be considered an integral component to the development of the work of the local tables.

Current Status

Strengthening the delivery of coordinated care through the development of coordinated care plans, to achieve the goals set in partnership with complex patients and their families, has been the focus of the Central East LHIN Health Links approach to care. Through the standardization of processes and formalization of partnerships between organizations, seamless ways of delivering care have been developed that will now be fully integrated into sub-regions and sub-region planning tables. The LHIN has appointed local Primary Care Physician Leads, in all seven of our sub-regions, to actively work with their local colleagues on transformative patient care improvements. The LHIN has made significant investments in home and community care services to ensure equitable access so that patients can live healthier at home.

Goals

- Bring together health system and community partners, as well as primary care and specialty clinical leadership, at the sub-region level to support and enable health system planning based on population health needs
- Identify, plan and make recommendations on innovative, integrated strategies for improvement in access and care delivery across and within sub-regions
- Be informed and guided by patient and family experience in improving patient transitions and coordination of care across the health care continuum
- Drive system change in sub-regions aligned to Central East LHIN and provincial priorities
- Develop stronger linkages between LHIN sub-region partner organizations and primary care providers
- Work with clinicians at the regional and sub-regional levels to support implementation of quality standards, in partnership with Health Quality Ontario (HQQ)
- Implement the ten steps identified in the *Patients First: A Roadmap to Strengthen Home and Community Care*

Consistency with Government Priorities

- *Patients First Act* (December 2016)
- *Patients First: Action Plan for Healthcare* (February 2015)
- *Personal Support Services Regulatory Amendments & Policy Implementation* (PSS Policy Implementation; 2014)
- *Patient Care Groups: A new model of population-based Primary Health Care for Ontario* (May 2015)
- *Patients First: A Roadmap to Strengthen Home and Community Care* (May 2015)
- *Home Care and Community Services Act* (1994)

Action Plans

SUB-REGION DEVELOPMENT and SUB-REGION PLANNING; PRIMARY CARE ALIGNMENT; HOME AND COMMUNITY							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
SUB-REGION DEVELOPMENT and SUB-REGION PLANNING							
LHIN sub-region tables	- Sub-regions - Primary Care alignment - Home and Community Care - Equity and Population Health - Community, Patient and Caregiver Engagement - Innovation and Best Practice	- Establish Sub-region tables - Ensure the participation of Health Service Providers, (including primary care, inter-professional health care teams, hospitals, public health, mental health and addictions and home and community care) patients, caregivers, francophone, indigenous stakeholders and other partners	- Seven sub-region tables established	- Identification of innovative and transformative actions, including advancing the Health Links approach to care - Strengthened relationship between sub-region membership, including Primary Care - Improved seamless patient experience	100	0	0
Sub-region profiles	- Sub-regions - Capacity Planning and ALC - Equity and Population Health	- Enhance existing (Phase 1) sub-region profiles - Launch (Phase 2) web-enabled sub-region profiles, including profiles of available services to include current resources, population health needs, etc.	- Web-enabled (Phase 2) sub-region profiles	- Increased knowledge of available services to meet sub-region population needs - Increased ability to develop informed plans to address health care needs	80	10	10
Capacity Planning	- Sub-regions - Primary Care - Home and Community Care	- Implement the provincial capacity plan that includes targets and standards for access to Home and Community Care and for the quality of client	- Inventory/database of information on Primary Care Health Human Resources and capacity	- Improved quality of client experience - Increased awareness of Health Human Resources by LHIN sub-region to	60	20	20

SUB-REGION DEVELOPMENT and SUB-REGION PLANNING; PRIMARY CARE ALIGNMENT; HOME AND COMMUNITY							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
	- Equity and Population need - Patient access - Community, Patient and Caregiver Engagement - Innovation and Best Practice	- experience - Based on available data from the provincial guidebook, complete a Primary Care Health Human Resources capacity assessment - Assess local population health needs, patient access and wait times	- Gap analysis - Capacity plan for Health Service provisions (identify gaps utilizing a health equity lense)	- inform planning - Improve access to primary care providers, including family doctors and nurse practitioners - Improve access to inter-professional health care providers to ensure comprehensive care			
Improving Patient Access to Care Providers and Settings	- Provincial Priorities - Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Capacity Planning and ALC - Community, Patient and Caregiver Engagement - Innovation and Best Practice	- In alignment with the Ministry, identify and prioritize services that require a coordinated Centralized Intake and Referral process (for example, see page 49) - Embed care coordinators and system navigators in primary care to ensure smooth transitions of care between home and community care and other health and social services	- Identification of services gaps - Prioritization of services - Co-ordinated Centralized Intake and Referral process for priority services	- Better patient experience through timely equitable access to the appropriate care - Better transitions for patients between service providers - Improved access to care	50	25	25
Health Links Approach to Care							
Coordinated Care Processes to improve transitions	- Sub-regions - Primary Care alignment - Home and Community Care - Equity and Population	- Strengthen transitions and care coordination processes within sub-regions - Formalize participation in	- Signed data sharing agreements to support care coordination - QI tests of change	- Improved ability to provide coordinated care between multiple health service providers and Primary Care	34	33	33

SUB-REGION DEVELOPMENT and SUB-REGION PLANNING; PRIMARY CARE ALIGNMENT; HOME AND COMMUNITY							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
	Health - Community, Patient and Caregiver Engagement - Innovation and Best Practice	- sub-region coordination of care initiatives by having each Health Service Provider (HSP) sign a "Letter of Commitment" and Data Sharing Agreement - Monitor performance metrics and obligations related to patient identification and participation in Coordinated Care Plan development in alignment with provincial indicator framework	projects - Continuing Medical Education Events on Care Coordination - Process Improvement Training - Community sharing events - Performance metrics and obligations included in Service Accountability Agreements	- Greater accountability of LHIN funded HSPs to participate in sub-region coordination of care initiatives and develop coordinated care planning processes for patients with complex needs			
Police-led collaborative (Situation Tables) with Health and Broader Social Service sector partners throughout the Central East LHIN	- Sub-regions - Primary Care alignment - Home and Community Care - Equity and Population Health - Community, Patient and Caregiver Engagement - Mental Health and Addictions - Innovation and Best Practice	- Formalize collaboration with the Situation Tables at the sub-region level and seek out opportunity to collaborate with other crisis response programs within the Central East LHIN	- Coordinated systems/ models for non-clinical support of complex patients in LHIN sub-regions	- Improved linkages between health, social service provider and crisis intervention models for individuals with complex needs - Improved coordination of services for individuals with complex care needs across service delivery continuum, taking into account social drivers (determinants) of health	50	50	0

SUB-REGION DEVELOPMENT and SUB-REGION PLANNING; PRIMARY CARE ALIGNMENT; HOME AND COMMUNITY							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
PRIMARY CARE ALIGNMENT							
Attaching Patients to Care	- Primary Care alignment - Equity & Population Health - Home and Community Care	- Working with the Ministry and Health Care Connect (HCC) program to implement strategies to increase the number of patients who have access to primary care	- Implement HCC program enhancement - Primary care waiting lists assessed by sub-region	- Increase patient access to a primary care provider	60	30	10
Business Model Options for Inter-Professional Primary Care Practices in LHIN sub-regions	- Performance Monitoring and Reporting - Sub-regions - Primary Care - Innovation and Best Practice	- Implement the provincial framework for inter-professional care	- List of potential models for implementation	- Better alignment of inter-professional primary care practices	25	50	25
HOME AND COMMUNITY CARE							
Statement of Values Focusing on Patient and Caregiver Centred Care	- Provincial Priority - Equity and Population Health - Community, patient and caregiver Engagement	- Implement the provincial Statement of Values	- Provincial Statement of Values implemented locally	- Increased awareness amongst patients, families, caregivers, and health service providers on the Statement of Values	100	0	0
Levels of Care Framework	- Provincial Priority - Sub-regions - Equity and Population	- Implement the Levels of Care Framework across Central East LHIN sub-	- Tools for providers	- Increased public awareness of Levels of Care Framework	50	50	0

SUB-REGION DEVELOPMENT and SUB-REGION PLANNING; PRIMARY CARE ALIGNMENT; HOME AND COMMUNITY							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
	Health	regions					
Plan for Increasing Self-Directed Care Options	- Provincial Priority - Sub-regions - Equity and Population Health	- Implement additional self-directed care across Central East LHIN sub-regions	- Self-directed care options for patients and caregivers	- Improved patient and caregiver experience	34	33	33
Integrated Funding Models (Bundled Care)	- Performance Monitoring and Reporting - Sub-regions - Equity & Population Health	- Support hospitals to enable the adoption of innovations in patient care, for example Integrated Funding Models	- Bundled Care service plans and programs, as approved	- Improved co-ordination between hospitals and home care providers	34	33	33
Personal Support Services (PSS) Regulatory Amendments, Policy Implementation Early Adopter	- Performance Monitoring and Reporting - Sub-regions - Equity and Population Health - Home and Community Care	- Identify appropriate patients to be transitioned to the Personal Support Worker (PSW) through the use of an algorithm that allocates the number of PSS hours to all eligible PSW clients including low to high needs patients	- Agencies using Personal Support Algorithm	- Patients experience a reduction in multiple assessments and enhanced consistency in level/type of service determination	34	33	33

Measuring Success

Metric	Reporting Level
Decrease low-acuity ED visits for LTCH residents	LHIN/SR/PC/HCC
% of acute care patients who have had a follow up with a physician within 7 days of discharge	LHIN/SR/PC/HCC
Rate of Emergency Visits best managed elsewhere	LHIN/SR/PC/HCC
Decrease unattached patients	LHIN/SR/PC/HCC
Reduction of readmission to hospital within 30 days	LHIN/SR/PC/HCC
Reduction of avoidable Emergency Department (ED) visits	LHIN/SR/PC/HCC
Decrease wait time for home care services after hospital discharge.	LHIN/SR/PC/HCC
Increase clients with MAPLe scores high and very high living in community supported by home and community providers.	LHIN/SR/PC/HCC

Note: SR = LHIN sub-region, PC = Primary Care, HCC = Home and Community Care

Risk/barrier to Successful Implementation

- Time and resources needed to action prioritized activities
- Effective involvement of all stakeholders

Mitigation Strategies

- Effective operationalization of the enhanced LHIN organizational structure
- Support local leadership, including Primary Care Physician Leads, to communicate and engage with all stakeholders

Key Enablers to Achieving Success

- Communications, Engagement and Change Management Strategy
- Effective integration of Digital Health initiatives

Central East LHIN Patient and Family Advisory Committee (PFAC)

Since its inception, the Central East LHIN has recognized the value of listening to the voice of patients and their family/caregivers. Taking action on the lived experience of patients and their caregivers has resulted in the establishment of new programs, improvements to existing services and, when warranted, the re-design or re-assignment of accountability for services.

Priority Description

In 2017/18, the Central East LHIN will continue to seek the advice of patients and caregivers through its Central East LHIN Patient and Family Advisory Committee (PFAC). The PFAC will both advise and collaborate with the Central East LHIN, its leaders, HSPs and staff regarding system-level policies, practices, and strategy, planning, and delivery of patient- and family-centred care within the Central East LHIN region. The PFAC will also support the involvement of patient and family caregivers at the sub-region planning tables.

Current Status

A LHIN wide Patient and Family Advisory Committee (PFAC) was established in 2016-17 and is currently comprised of seven individuals, who have been patients, or caregivers of patients in the Central East LHIN. The inaugural membership reflects the diversity of the people and communities within the LHIN.

Goals

The PFAC will work with the LHIN to:

- Identify strategic priorities relating to patient- and family-centred care, and supporting/ co-designing solutions to help realize these priorities
- Provide direction and support on system-level practice change relating to patient- and family-centred care
- Develop draft policies or position papers in support of policy change aimed at supporting patient- and family-centred care
- Identify opportunities for improving quality of care in the Central East LHIN, and participate in quality improvement activities
- Establish a strategy to increase meaningful patient engagement, and advance the culture of patient- and family-centred care within the Central East LHIN
- Ensure the involvement of patient and families at other committees and networks

Consistency with Government Priorities

- *Bringing Care Home – Report of the Expert Group on Home and Community Care* (March 2015)
- *Patients First: Action Plan for Health Care* (February 2015)

Action Plans

CENTRAL EAST LHIN PATIENT AND FAMILY ADVISORY COMMITTEE (PFAC)							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status(%) complete IHSP Yr. 1/2/3		
					2017/18	2018/19	2019/20
Patient and Family Advisory Committee (PFAC)	- Provincial Priorities - Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Community, Patient and Caregiver Engagement - Mental Health and Addictions - Capacity Planning and ALC - Innovation and Best Practice	- The PFAC will provide advice to the Central East LHIN on key issues affecting the health care system - Patient and Caregiver/Family Engagement at the sub-region level - Self-management and the provision of caregiver supports to reduce caregiver distress	- Finalized Terms of Reference and Work Plan - Improved patient and caregiver experience - Increased programming	- Increased engagement and involvement of families and caregivers in health care system decision-making - Improving transitions for patients between different health sectors - Reduction of caregiver distress	34	33	33

Measuring Success

Metric	Reporting Level
Measure the involvement of Patient and Family Caregivers in health care decision-making	LHIN

Risk/barrier to Successful Implementation

- “Traditional” methods of engaging with Patient and Family Caregivers is not always effective with vulnerable populations
- Challenges with recruiting diverse representatives including cultural and ethnic communities
- Availability of time and resources of Patient and Family Caregivers to participate

Mitigation Strategies

- Work in partnership with vulnerable people, their supports, and networks in order to make processes as accessible as possible within their own individual contexts.
- Actively recruit diverse membership through multiple marketing channels
- Provide support and resources for participation

Key Enablers to Achieving the Patient and Caregiver Direct Care Priority

- Senior Leadership support of PFAC and its activities

HEALTH EQUITY - DIVERSITY AND BUILDING CULTURAL COMPETENCY

Within each of the four Strategic Aims, certain patient groups are recognized as priority populations, including the Francophone community, Indigenous Peoples and new immigrants. Health equity is influenced by the accessibility to health care services and the quality of the services received. Racial, ethnic, linguistic and gender differences, recent immigration, as well as being a member of a marginalized population can result in inequitable access to care.

Priority Description

In the 2016-19 IHSP a commitment to better serve the increasing number of Francophone, Indigenous Peoples and new immigrants was established. The Central East LHIN will support the advancement of a health care system that is capable of delivering the highest quality care at the local level to any patient, regardless of race, ethnicity, culture or language capacity; this includes diversity and cultural competency education and awareness training for HSPs and the development of performance indicators that support diversity and build cultural competency.

Through its work the LHIN will continue to identify high risk populations and work with public health and local community partners to implement targeted interventions to improve access to appropriate and culturally sensitive care, within each of our sub-regions.

In undertaking its mandate, the Central East LHIN will continue to promote health equity by reducing health disparities and inequities, respecting the diversity of communities in the planning, design, delivery and evaluation of services and continuing to strengthen engagement with both the Francophone and Indigenous communities.

Current Status

French Language Services (FLS)

The 2017/18 ABP furthers our continuing improvement of the services to support our Francophone population. This includes advancing a health care system that is culturally competent and capable of delivering the highest quality care at the local level through diversity and cultural competency education and awareness training for HSPs and the development of performance indicators that support diversity.

The Central East LHIN is continuing to work with HSPs to advance access to French Language Services (FLS) for the growing francophone population of the Central East region. This work is guided by the Annual Joint Action Plan between the Central East LHIN and the French Language Health Planning Entity (Entité 4) and will continue to be supported by the Coalition for Healthy Francophone Communities in Scarborough, the Francophone Community Table on Health of Durham Region, and additional community partners. It involves annual monitoring and reporting from HSPs, including Home and Community Care, to ensure ongoing capacity and access to a growing basket of French-language health services. Identification of FLS HSPs is continuing, including the promotion and provision of the principle of Active Offer, supporting pro-active offer of FLS from first point of contact, where possible.

Indigenous Peoples

The 2017/18 ABP continues the collaboration with the Indigenous communities located within the Central East LHIN boundaries, as well as with those Indigenous Peoples residing outside of their communities and within urban centres.

The Central East LHIN established two Health Advisory Circles in 2010: The Central East LHIN First Nations Health Advisory Circle and the Metis, Non-Status, Inuit Health Advisory Circle. The Central East LHIN will continue to work with the Circles to plan, implement, and evaluate health care services in order to ensure they are both culturally safe and appropriate to their needs. The membership of the Central East LHIN Metis, Non-Status, Inuit Health Advisory Circle expanded significantly in 2015/16 to include members from both the Northeast and South Durham off-territory and urban communities. This now permits the Central East LHIN to connect with communities that have not been included in past planning work.

The LHIN did support the implementation of Indigenous Outreach Services to the Northeast, Durham and Scarborough Clusters by working with Indigenous Community members to implement Indigenous Mental Health and Addictions Outreach positions.

In addition, there has been work done to ensure that Central East LHIN staff, Board of Directors, and HSPs are able to offer services in a culturally safe manner through the provision of foundational cultural safety training. This training has been provided to all members of the Central East LHIN Board of Directors and staff, as well as to the full complement of community crisis service providers throughout the Central East LHIN.

Both Indigenous Health Planning Circles were engaged by the Central East LHIN prior to the Community Engagement process related to the development of the 2016-19 IHSP. The advice of the Indigenous Health Planning Circles is well integrated into the content of IHSP 4, and not restricted to any one section.

New Immigrants

In 2011, immigrants accounted for 33.2% of the Central East LHIN population. Approximately 4% of Central East LHIN residents were recent immigrants, having arrived in Canada between 2006 and 2011.

In response to the increased number of Syrian refugees being resettled in the Central East LHIN and the continued welcoming of new immigrants to our communities, the Central East LHIN continues to respond and prepare to meet their health needs through a multi-stakeholder planning and coordination table.

Members include local health system leaders/representatives from primary care, hospitals, mental health, public health, dental, paramedic and other key partners likely to be involved with refugee and new immigrant health care. The Central East LHIN will continue to ensure that these partners are well integrated in the establishment and implementation of LHIN sub-region planning tables to support ongoing and future coordinated responses.

Goals

- Build cultural competency amongst Central East LHIN Health Service Providers and broader system partners in order to reduce barriers and improve access to equitable care that support diverse populations, including Francophones, Indigenous peoples, and new immigrants.

Consistency with Government Priorities

- Excellent Care for All Act (2010)
- Health Equity into Action: Planning and Other Resources for LHINs (2010)
- Patients First: Action Plan for Health Care (February 2015)
- Honouring the Truth, Reconciling for the Future (2015)

Action Plan

HEALTH EQUITY - DIVERSITY AND BUILDING CULTURAL COMPETENCY							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status(%) complete		
					2017/18	2018/19	2019/20
FRENCH LANGUAGE SERVICES (FLS)							
Francophone Community Table on Health – North East cluster	- Provincial Priorities - Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Community, Patient and Caregiver Engagement - Capacity Planning and ALC - Mental Health and Addictions	- Establish an integrated North East cluster Francophone stakeholder planning table	- The decision was made not to establish a Francophone engagement structure in the Northeast Cluster of the LHIN due to what appears to be a low level of interest. The LHIN will continue to work with its Francophone contacts in the area to engage with Francophone	- Francophone stakeholders actively engaged across all seven Central East LHIN sub-regions - Strengthen health services in French	40	30	30

HEALTH EQUITY - DIVERSITY AND BUILDING CULTURAL COMPETENCY							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status(%) complete		
					2017/18	2018/19	2019/20
	- Innovation and Best Practice		service recipients and will engage them in all Northeast Cluster focused planning activities				
Annual Joint Action Plan	- Provincial Priorities - Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Community, Patient and Caregiver Engagement - Capacity Planning and ALC - Mental Health and Addictions - Innovation and Best Practice	- Develop FLS seniors services including Adult Day Program (ADP), Falls Prevention, Assisted Living - Expand access to FLS mental health and addictions services - Expand access to FLS primary care services - Establish FLS memory clinic models focusing on early detection/intervention, prevention, treatment tools for seniors dealing with mild cognitive impairment	- FLS programs and services in Seniors, Primary Care, Mental Health and Addictions, Chronic Diseases and Self-Management	- Access for seniors to services adapted to linguistic and cultural needs - Improved quality of life for Francophone patients and caregivers dealing with mild cognitive impairment - Improve access to appropriate and culturally sensitive care and improve health outcomes	30	35	35
INDIGENOUS PEOPLES							
Indigenous Peoples Services	- Provincial Priorities - Sub-regions - Primary Care - Home and Community Care	- Indigenous Outreach Services are established in Scarborough - The Central East LHIN will work actively with Health Service Providers	- Indigenous Outreach Workers are in place and offering services to Indigenous residents - Cultural safety training for HSPs and other	- Indigenous Peoples are involved in co-design of services in their communities - Improved quality of life and client satisfaction	34	33	33

HEALTH EQUITY - DIVERSITY AND BUILDING CULTURAL COMPETENCY							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status(%) complete		
					2017/18	2018/19	2019/20
	- Equity and Population Health - Community, Patient and Caregiver Engagement - Mental Health and Addictions - Innovation and Best Practice	to ensure their services are offered in a culturally safe manner to the Indigenous Peoples they serve. Additional Indigenous cultural safety training will be offered	stakeholders	- for Indigenous People - Increased capacity to deliver cultural competent services			
NEW IMMIGRANTS							
New Immigrants access to comprehensive Primary Health Care Programs	- Provincial Priorities - Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Innovation and Best Practice	- Explore models for delivery of comprehensive primary care services for new immigrants - Strengthen relationships between primary care providers and settlement agencies across sub-regions	- The LHIN will establish a table to review current Health Equity practices for the new Immigrant and diverse population it serves in order to ensure equity of access, service provision and accountability across the Central East LHIN	- Improved access to culturally sensitive primary care for new immigrants	50	25	25

Measuring Success

Metric	Reporting Level
Measure the delivery of FLS services as per HSP Service Accountability Agreements	LHIN
Measure the number of HSPs who participated in Cultural Safety Training	LHIN
Monitor relationship building between Primary Care providers and settlement agencies	LHIN

Risk/barrier to Successful Implementation

- Lack of Francophone stakeholders and community engagement and/or involvement
- Issues related to establishing trust with Indigenous Peoples and communities
- Availability of culturally appropriate resources to meet the needs of these priority populations

Mitigation Strategies

- Ensure timely and comprehensive Francophone stakeholder engagement occurs
- Open dialogue and transparency with Indigenous communities and partners
- Active recruitment and identification of culturally competent health service providers

Key Enablers to Achieving the Health Equity-Diversity and Building Cultural Competency

- Senior Leadership support of Health Equity – Diversity and Building Cultural Competency and Central East LHIN Health Equity – Diversity Framework

STRATEGIC AIMS

SENIORS AIM

Continue to support frail older adults to live healthier at home by spending 20,000 fewer days in hospital and reducing Alternate Level of Care days for people age 75+ by 20% by 2019.

Priority Description

The Central East LHIN is committed to supporting frail seniors in avoiding hospitalization and transitioning safely home following a necessary hospital stay. The Seniors Aim is a system-level, population health strategic aim focused on improving the health care services for and with frail seniors and their caregivers.

Current Status

Frail seniors are those older adults whose complex health concerns threaten their independence and function. In the Central East LHIN, the frail senior population is growing and continues to effect and shape the demand for health care services. The Central East LHIN, the Seniors Care Network, and the newly created role of a Seniors' Physician Lead, along with key stakeholders and partners, will design, implement and evaluate programs that strengthen integrative health services and their delivery for frail seniors. The focus of this work in 2017/18 will be to better understand frail senior populations at a LHIN sub-region level and the opportunities to meet their health needs to support them living at home.

Support Structures, Frameworks, Networks/Committees

The **Seniors Care Network** was established and funded by the Central East LHIN to improve the planning and coordination of specialized geriatric health services for frail seniors throughout the Central East LHIN with emphasis on reducing unnecessary hospitalizations and supporting frail seniors to continue living at home safely.

Goals

- Support frail older adults to live healthier at home by spending fewer days in hospital
- Continue to provide ongoing alternatives for home and specialized care that helps older adults to remain living healthier at home and in their community

- Continue to support existing initiatives, expand community-based services, and implement new strategies related to dementia so that patients will only have to stay in hospital as long as they need the intensity of care that hospitals are designed to provide
- Expand access to services that support seniors' independence and functioning, including restorative care, adult day programs, and assisted living services for high risk seniors

Consistency with Government Priorities

- *Bringing Care Home – Report of the Expert Group on Home and Community Care* (March 2015)
- *Provincial Seniors Strategy – Living Longer, Living Well* (2012)
- *Building a Model of Sustainable Access to Community Health Care Services* (2011)
- *Ministry's Specialized Geriatric Services and Regional Geriatric Programs: Review and Recommendation* (December 2014)
- *Enhanced Long-Term Care Home Renewal Strategy* (2014)

Action Plans

SENIORS							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
FRAIL SENIORS							
Long-Term Care Home (LTCH) Redevelopment Project (2016-2025)	- Capacity Planning and ALC	- Redevelopment planning for LTCHs - Decanting strategy - Senior Friendly Care (SFC) and Behavioural Supports Ontario (BSO) design principles developed	- LHIN input to the ministry on licensing proposals - Support for redevelopment plans, inclusive of SFC and BSO design principles	- Older LTCHs brought up to the highest design standards - Best practices for SFC and BSO incorporated in design principles	10	40	50
Memory Services	- Primary Care - Mental Health and Addictions - Innovation and Best	- Gap analysis at the sub-region level to determine demand for services - Implementation of a regional	- Integrated patient flow processes - Evaluation completed - Gap analysis completed	- Increased early diagnosis and intervention - Improved access to specialized geriatric and	75	25	0

SENIORS							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
	Practice - Provincial Priorities - Sub-regions - Equity and population Health	system of primary care-based memory services - Evaluation of current memory services		neurocognitive services - Increased participating primary care practices			
Adult Day Programs (ADP)	- Capacity Planning and ALC - Innovation and Best Practice - Home and Community - Community, Patient and Caregiver Engagement	- Evaluate existing programs and conduct a gap analysis at the sub-region level - Spread programming and fill any gaps at the sub-region level	- Gap analysis completed - Additional ADP	- Increased provision of ADP services - Increased respite options and caregiver support	50	25	25
Caregiver Education and Training	- Capacity Planning and ALC - Innovation and Best Practice - Home and Community - Community, Patient and Caregiver Engagement	- Develop and submit an Expression of Interest to create a framework for caregiver education and training for the care of people living with frailty and dementia, leveraging local and provincial efforts	- Expression of Interest	- Increased education for caregivers of people living with frailty	50	50	0
SUPPORTED LIVING ENVIRONMENTS							
Assisted Living Services for High Risk Seniors (ALS-HRS)	- Capacity Planning and ALC - Innovation and Best Practice	- Evaluate existing programs and conduct a gap analysis at the sub-region level - Spread programming and fill any gaps at the sub-region	- Gap analysis completed - Additional ALS-HRS	- Increased provision of ALS-HRS - Clients maintaining independence in the	25	25	50

SENIORS							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
	- Home and Community - Community, Patient and Caregiver Engagement	level		community - Increased respite options and caregiver support			
PHYSIOTHERAPY AND REHABILITATION							
Rehabilitation Steering Committee	- Capacity Planning and ALC - Innovation and Best Practice - Home and Community	- Establish a Regional Rehabilitation Steering Committee	- Steering Committee established	- Optimized rehabilitation care in the Central East LHIN	100	0	0
Capacity Planning for Rehabilitation Services	- Capacity Planning and ALC	- Review existing capacity of rehabilitation services in the Central East LHIN, including physiotherapy clinics	- Rehabilitation capacity plan for the Central East LHIN	- Understanding of the rehabilitation resources in the Central East LHIN by sub-region, to better inform future planning	25	25	50
Assess and Restore (A&R)	- Capacity Planning and ALC - Innovation and Best Practice - Home and Community	- Evaluate existing Assess and Restore initiatives - Develop a sustainability plan for the ongoing delivery for Assess and Restore, incorporating high-value components	- Evaluation plan for Assess and Restore initiatives - Sustainability plans for Assess and Restore initiatives	- Improved integration of Assess and Restore initiatives with other relevant services	100	0	0

Measuring Success

Metric	Reporting Level
Alternate Level of Care (ALC) days for people age (75+)	LHIN/SR/Hospital
Reduce Falls Related ED Visits	LHIN/SR/Hospital

Metric	Reporting Level
Decrease low-acuity ED visits for LTCH residents	LHIN/SR/Hospital
% of home care clients with complex needs who receive their nursing and/or personal support service within 5 days	LHIN/SR
CCAC wait-time from application to eligibility determination from community or acute care setting	LHIN/SR
Decrease wait time for home care services after hospital discharge	LHIN/SR
Increase clients with MAPLe scores high and very high living in community supported by CCAC or community providers	LHIN/SR

Note: SR = LHIN sub-region

Strategic Aim	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
20,000 days spent living healthier at home equates to 20,000 less days spent in hospital. As such, efforts to reduce hospital days will be a core focus: Reduce ALC days for people age 75+	Implement	50	Implement	50		0

Risks/barriers to successful implementation

- Frail seniors population and care needs are continuing to increase
- Increased burden on family caregivers
- Lack of equitable Health Human Resources across the seven sub-regions to support geriatric population

Mitigation Strategies

- Work with sub-region planning tables to understand and respond to need
- Continue to offer innovative self-management education programs for family caregivers
- Work with Health Force Ontario and the Seniors' Physician Lead to increase recruitment of physicians with geriatric expertise

Key Enablers to achieve the Senior Aim

- Support and leadership of the Seniors Physician Lead and Seniors Care Network and ongoing implementation of the Seniors Friendly Care strategy

VASCULAR HEALTH AIM

Continue to improve the vascular health of people to live healthier at home by spending 6,000 fewer days in hospital and reducing hospital readmissions for vascular conditions by 11% by 2019.

Priority Description

Vascular diseases remain the leading cause of preventable death in adult Canadian men and women. Despite reductions in the number of people who die each year from vascular diseases, this remains the number one threat to the health of Canadians. In 2017/18, the Central East LHIN will continue to support strong inter-sectoral partnerships between hospitals, primary and specialty care, and community organizations, patients, their families, and caregivers.

Current Status

Vascular health has been a strategic aim for the Central East LHIN since 2006 with close to 70,000 inpatient days saved for vascular conditions. The LHIN is continuing to support the achievement of this aim with education and communication for patients and caregivers, stronger linkages with primary health care, and improved system navigation processes.

Support Structures, Frameworks, Networks/Committees

The **Vascular Health Strategic Aim Coalition** was established to lead and provide oversight to the achievement of the priorities contained in the Central East LHIN's Integrated Health Service Plan. The Vascular Health Strategic Aim Coalition applies quality improvement methodologies including the application of the Institute for Healthcare Improvement's (IHI) Triple Aim Framework and the LHIN's own mission of improving population health, obtaining better value for money and improving the patient experience.

Goals

- To continue to improve the organization, coordination, and delivery of vascular health services for residents in the Central East LHIN across LHIN sub-regions, with the goal of reducing hospitalization, readmissions to hospitals, and promoting vascular health
- Establish equitable access for vascular services and care
- Advance goals of patient and caregivers by improving identification of patients with complex diabetes, vascular, congestive heart failure and social care needs, and conducting coordinated care planning
- Improve linkages to primary health care and community resources
- Ensure needs of Francophone, Indigenous people, and new immigrants are being addressed

Consistency with Government Priorities

- *The Ontario Integrated Vascular Health Strategy (OIVHS) - Blueprint* (2012)
- *Ontario Diabetes Strategy* (July 2008)
- *Ontario Renal Plan* (2015–2019)

Action Plans

VASCULAR HEALTH							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
Telewound Care Project	- Innovation and Best Practice - Home and Community Care - Digital Health	- Develop the Telewound model of care for the Central East LHIN	- Pilot project completed with OTN	- Increased integrated access to care	100	0	0
Telehomecare	- Digital Health - Innovation and Best Practice - Community, Patient and Caregiver Engagement - Equity and Population Health - Home and Community Care - Capacity Planning and ALC	- Evaluate Telehomecare implementation throughout the Central East LHIN	- Program evaluation and recommendations for program expansion - Strategic approach to OTN based services	- Better access to care closer to home	70	30	0
Stroke Strategy	- Provincial Priorities - Sub-regions - Primary Care - Equity and Population Health	- Capacity Review - Establish a Central East LHIN Stroke Committee - Evaluate stroke services in the Central East LHIN, including a sub-region	- Stroke services plan - Development of regional stroke work plan - Integrated service plan – GTA stroke	- Improve the understanding of the status of stroke services in the Central East LHIN - Integrated stroke service delivery	34	33	33

VASCULAR HEALTH							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
	- Home and Community Care - Capacity Planning and ALC	- analysis of access to stroke care across the continuum of care - Cross GTA-LHIN Stroke Collaboration GTA support for common approach to community stroke care	- plan; implementation of plan - Integration with rehabilitation capacity review	across the GTA LHINs			
Diabetes Education Program (DEP)	- Sub-regions - Primary Care - Community Patient and Caregiver Engagement - Equity and Population Health - Home and Community Care	- Conduct a review of foot care resources by sub-region - Identify gaps and opportunities for DEPs - Lead DEPs to develop a patient experience tool - Lead DEPs to optimize eye care screening for diabetic patients - Review and recommend improvements to transition clients from paediatric DEP to adult DEP	- Review completed - Patient experience tool - Reporting on patient experience - Quarterly reporting - Recommendations for transitions	- Increased access to and equitable foot care within each LHIN sub-region - Improved patient experience - Increased eye examination rates - Improve the transition process	50	50	0
Self-Management	- Provincial Priorities - Sub-regions - Primary Care - Equity and Population Health - Home and Community Care - Capacity Planning and ALC	- Implement culturally appropriate education/workshops (Francophone, Indigenous peoples) - Evaluate utilization of the program to identify opportunities	- Francophone workshops - Client satisfaction/patient experience survey - Caregiver Self-Management	- Improved access to care - Decreased hospital readmissions - Improved access to culturally appropriate care	50	50	0

VASCULAR HEALTH							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
	- Public Health - Innovation and Best Practice	- Monitor performance/ funding for provincial clinician training monies - Spread the Caregiver Self-Management Program across the Central East LHIN - Investigate options and opportunities to offer self-management programming that is relevant to immigrant populations	Programs	- Improved access to appropriate services for specific chronic conditions - Increase Caregiver Self-Management Programs			
Regional Cardiovascular Rehabilitation and Secondary Prevention	- Provincial Priorities - Innovation and Best Practice - Home and Community Care - Primary Care	- Evaluation of the program	- Evaluation report	- Increased integrated access to care - Increased clients served within 30-minutes travel - Reduced hospital readmissions	100	0	0

Measuring Success

Metric	Reporting Level
# of inpatient days saved	LHIN/SR/Hospital
30-day Re-admission for select Case Mix Group (CMG) (CHF)	LHIN/SR/Hospital
30-day Re-admission for select CMG (COPD)	LHIN/SR/Hospital
30-day Re-admission for select Case Mix Group (Diabetes)	LHIN/SR/Hospital
Percentage ALC days (stroke)	LHIN/SR/Hospital
Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation	LHIN/SR/Hospital
Proportion of stroke/TIA patients treated on a stroke unit and time during their inpatient stay	LHIN/SR/Hospital

Note: SR = LHIN sub-region

Strategic Aim	2017/18		2018/19		2019/20
	Status	%	Status	%	Status
6,000 days spent living healthier at home equates to 6,000 less days spent in hospital. As such, efforts to reduce avoidable hospital readmissions will be a core focus: - Reducing readmissions to hospital; - Preventing initial hospitalizations; and, - Reducing hospital days due to preventable adverse events in hospital	Implement	50	Implement	50	

Risk/barriers to Successful Implementation

- Overlapping Stroke Network boundaries across the Central East LHIN

Mitigation Strategies

- Central East LHIN Stroke working group will support collaboration of stroke networks

Key Enablers Achieving Vascular Care Aim

- Digital Health initiatives
- Clinical and administrative system support and leadership

MENTAL HEALTH AND ADDICTIONS AIM

Continue to support people to achieve an optimal level of mental health and live healthier at home by spending 15,000 fewer days in hospital and reducing repeat unscheduled emergency department visits for reasons of mental health or addictions by 13% by 2019.

Priority Description

The Central East LHIN is committed to ensuring that high quality and equitable health care is available to those who are affected by mental health and addictions (MHA) issues in accessing the primary health care system and other broader health supports.

If appropriate care is not provided, people with mental health and/or addictions issues are often frequent users of urgent care. In 2013/14 there were 23,468 unscheduled ED visits in the Central East LHIN where the presenting issue was a MHA condition and an additional 5,777 visits where MHA was concurrent with the presenting condition. Between 2010/11 and 2013/14, there was a 20.1% growth in visits to the ED for MHA suggesting a growing need and that the care and supports needed to live healthier at home can still be improved.

Current Status

Mental health and addictions has been a strategic aim for the Central East LHIN since 2006, saving a predicted 30,786 hospital inpatient days by the end of IHSP 2013-2016. Based on current and future system service partnerships, system planning, targeted funding and overall investments, the Central East LHIN and its health service providers continue to work together to meet the MLAA targets for Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions and Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions on a consistent basis.

Supporting Structures, Frameworks, Networks/Committees

The Central East LHIN Mental Health and Addictions Coordinating Council: Oversees and monitors the achievement of the Central East LHIN's Mental Health and Addictions Strategic Aim and priority projects.

Goals

- Provide alternatives to hospital-based care through integration and better linkages with primary care, specialists and supported living environments
- Improved support in primary care settings through heightened coordinated care planning, advance care planning, and education

Consistency with Government Priorities

- Minister's *10 Year Strategy for Mental Health: Every Door is the Right Door* (2009)
- *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (2011)
- *Realizing Our Potential: Ontario's Poverty Reduction Strategy* (2014-2019)
- *Work with our local partners to map and expand access to structured psychotherapy, supportive housing and strengthen referral networks with primary care providers*

Action Plans

MENTAL HEALTH AND ADDICTIONS							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
Mental Health and Addictions Review	- Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Community, Patient and Caregiver Engagement - Capacity Planning and ALC - Mental Health and Addictions - Innovation and Best Practice	- Receive, review and implement the Mental Health and Addictions Deloitte Consultation (Central East LHIN Mental Health & Addictions Scan)	- Implementation plan developed in partnership with providers, service users, caregivers and other partners	- Improved understanding and agreement by health service providers on improving access for service users, including expanding access to psychotherapy	100	0	0
Crisis Response Services	- Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Community, Patient and Caregiver Engagement - Capacity Planning and ALC - Mental Health and Addictions - Innovation and Best Practice	- Assessment of the outcomes of the Crisis Response Service investments - Review recommendations and develop implementation plan	- Gap Analysis - Implementation plan	- Improved understanding and agreement by health service providers on improving access for service users	50	50	0
ACTT Together	- Sub-regions - Primary Care - Home and Community Care - Equity and Population Health	- Work with academic sources to produce an evaluation report	- Evaluation report published in an academic journal	- Improved understanding and agreement by health service providers on improving access for service users	50	50	0

MENTAL HEALTH AND ADDICTIONS							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
	- Community, Patient and Caregiver Engagement - Capacity Planning and ALC - Mental Health and Addictions - Innovation and Best Practice						
Child and Adolescent Hospital-Based Psychiatric Services Project	- Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Community, Patient and Caregiver Engagement - Capacity Planning and ALC - Mental Health and Addictions - Innovation and Best Practice	- Implement recommended improvements via inter-sectoral partnerships	- Improvements implemented	- Improved understanding and agreement by health service providers on improving access for service users	50	50	0
Dual Diagnosis (DD) Framework	- Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Community, Patient and Caregiver Engagement - Capacity Planning and ALC - Mental Health and Addictions - Innovation and Best Practice	- Implement DD Framework in partnership with cross-sectoral partners	- DD Framework completed	- Enhanced monitoring of clients	50	50	0

MENTAL HEALTH AND ADDICTIONS							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
LHIN-Wide Opioid Strategy	- Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Community, Patient and Caregiver Engagement - Capacity Planning and ALC - Mental Health and Addictions - Innovation and Best Practice	- Develop LHIN-Wide Opioid Strategy in partnership hospital, MHA, Police and EMS partners	- Select hospitals to champion development and implementation of Opioid policies, including Naloxone education and training for ED physicians	- Enhanced monitoring of clients - Improved access to care - Decreased hospital readmissions	0	0	100%

Measuring Success

Metric	Reporting Level
# of inpatient days saved	LHIN/SR/Hospital
Number of hospital inpatient bed days	LHIN/SR/Hospital
Repeat unscheduled emergency department visits for mental health	LHIN/SR/Hospital
Repeat unscheduled emergency department visits for substance abuse	LHIN/SR/Hospital
Proportion of discharges sent home rather than to an institution for patients with a behaviour support diagnosis	LHIN/SR/Hospital
Transfers from LTC to ED; Mental health patients only; rate per 1000	LHIN/SR/Hospital

Note: SR = LHIN sub-region

Strategic Aim	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
15,000 days spent living healthier at home equates to 15,000 fewer days in hospital. As such, efforts to reduce avoidable hospital readmissions will be a core focus: • Fewer days in hospital • Reducing repeat unscheduled emergency department visits	Implement	50	Implement	50		0

Risk/barrier to Successful Implementation

- Capacity of HSPs to participate in innovative, collaborative service delivery models
- Increasing volume of service users requiring mental health and addictions support
- Lack of comprehensive primary care for service users in the community

Mitigation Strategies

- Work with Mental Health and Addictions Physician Lead to increase capacity of system to work in collaboration
- Work with sub-region planning tables to understand and respond to need

Key Enablers Achieving Mental Health and Addictions Aim

- Digital Health initiatives
- Clinical and administrative system support and leadership

PALLIATIVE CARE AIM

Continue to support palliative patients to die at home by choice and spend 15,000 fewer days in hospital by increasing the number of people discharged home with support by 17% by 2019.

Priority Description

Palliative and end-of-life care aims to relieve suffering and focus on achieving comfort. Incumbent in the care is respect for the persons nearing death and maximizing quality of life for the patient, family and loved ones. It is holistic in nature and encompasses physical, psychological, social, spiritual and practical issues.

Current Status

Ongoing achievement of the Palliative Care Strategic Aim requires the coordinated actions of hospitals, primary and specialty care, the home and community care organizations in partnership with patients and their families. As such, there are a number of palliative care priority projects and investments which have contributed to and will continue to contribute to attainment of our aim.

Supporting Structures, Frameworks, Networks/Committees

Central East Regional Palliative Care Steering Committee (CERPCSC): The Central East Regional Palliative Care Steering Committee (CERPCSC) is a disease-agnostic network designed to support a coordinated, standardized approach for the delivery of hospice palliative care services in the Central East region.

Goals

- Increased capacity by redirecting services from acute care settings into communities
- Increased access and opportunity for patients to receive palliative and end-of-life care within their homes and communities through establishment, expansion, and enhancements of interdisciplinary community-based palliative teams
- Increased access to residential hospice as a choice for location of death
- Heightened quality and safety through increased education and training opportunities
- Improved support in primary care settings through heightened coordinated care planning, advance care planning, and education
- Improved system design and integration opportunities through continued development of informal support networks and development of Community Hospice Hub models

Consistency with Government Priorities

- Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action (December 2011)
- The Ontario Palliative Care Network (OPCN) mandate and direction

Action Plans

PALLIATIVE CARE							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
Palliative Care							
Central East Regional Palliative Care Strategy and Action Plan	- Provincial Priorities - Sub-regions - Primary Care	- Develop the regional Palliative Care Strategic Plan and Action Plan	- Regional Strategic Plan and Action Plan	- Improved access to integrated systems of high quality palliative care to support the patient and	60	30	10

PALLIATIVE CARE							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
	- Home and Community Care - Equity and Population Health - Innovation and Best Practice - Capacity Planning and ALC - Community, patient and Caregiver Engagement - Innovation and Best Practice	- Initiate implementation of Action Plan		caregiver			
Community Hospices as Hubs	- Provincial Priorities - Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Innovation and Best Practice - Capacity Planning and ALC	- Develop "Centres of Excellence in Hospice Palliative Care", grief and bereavement services in community hospice hubs	- Grief and bereavement services offered throughout community/caregiver support groups by LHIN sub-region - Common basket of core programs and services available across local hospice settings, based on need	- Equitable access to services across communities - Enhancements in coordinated care planning across sectors - Increased access to, and coordination of holistic hospice palliative and end-of-life care services for patients, families and caregivers	50	50	0
Community Palliative Care for Vulnerable and Underserved Populations	- Provincial Priorities - Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Innovation and Best Practice - Capacity Planning and ALC	- Development of a model and proposal through partnership with local health and social service stakeholders to improve access to hospice palliative care for the homeless in the Central East LHIN	- A proposal to improve access to hospice palliative care for the homeless in the Central East LHIN - A plan to address service needs and gaps	- Partnerships with local health and social service stakeholders - Expanding existing service delivery models for vulnerable populations	80	20	0

PALLIATIVE CARE							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
Medical Assistance in Dying (MAID)	- Sub-regions - Equity and Population Health - Home and Community Care - Community, patient and Caregiver Engagement - Innovation and Best Practice	- Support the development of a Central East LHIN MAID Working Group regional plan	- A regional plan for the provision of MAID services in Central East LHIN	- As an end-of-life care option, MAID and palliative care planning are being done collaboratively - Integrated, informed, connected, patient-centred provision of MAID across Central East - Equity and access for all persons in any organization in the Central East LHIN	100	0	0
Palliative Care Community Teams (PCCTs)	- Provincial Priorities - Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Innovation and Best Practice - Capacity Planning and ALC - Community, Patient and Caregiver Engagement	- Consensus on a standardized regional model of care for all 6 PCCTs	- A standardized regional model of care for all 6 PCCTs	- Equitable access to services across communities - Enhancements in coordinated care planning across sectors - Increased quality of care for patients and families	100	0	0

PALLIATIVE CARE							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status (%) complete		
					2017/18	2018/19	2019/20
Supported Living Environments							
Residential Hospice	- Provincial Priorities - Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Innovation and Best Practice - Capacity Planning and ALC - Community, Patient and Caregiver Engagement	- Continue to pursue innovative opportunities for residential hospice - Develop 53 residential hospice beds	- Residential hospices opened and beds operational	- Increased access and opportunity for patients to receive palliative and end-of-life care within their communities	40	60	0

Measuring Success

Metric	Reporting Level
Decrease hospital length of stay for palliative patients	LHIN/Hospital
Decrease in palliative patients who die in hospital	LHIN/Hospital
Decrease ALC days for palliative patients	LHIN/Hospital
Increase number of Coordinated Care Plans	SR/LHIN
Increase patients discharged home with the support they need	LHIN/Hospital

Note: SR = LHIN sub-region

Strategic Aim	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
15,000 days spent living healthier at home equates to 15,000 fewer days in hospital. As such, efforts to reduce avoidable hospital readmissions will be a core focus: Increase number of people discharged home with supports	Implement	50	Implement	50	Implement	0

Risk/barrier to Successful Implementation

- Capacity of system partners to action provincial initiatives
- Limited human resources and lack of appropriately trained staff (i.e. increased demand for community nurse practitioners, physicians, nurses and personal support workers); and
- Family and caregiver demands; client perception of need

Mitigation Strategies

- Development of more effective relationships and referral patterns between hospital and community providers
- Continued collaboration and leadership from Central East Palliative Care Physician Lead
- Central East LHIN collaboration with MOHLTC, OPCN, CERPCSC, Provincial End-of-Life Network Partners, Cancer Care Ontario's Central East Regional Cancer Program and other LHINs

Key Enablers to achieve Palliative Care Aim

- Ongoing engagement and collaboration with hospice, palliative, and end-of-life leadership from across the Central East LHIN
- Digital Health initiatives

DIRECT CARE PRIORITIES

Supported Living Environments

Safe, affordable, stable housing with the services necessary to support people of all ages to live healthier at home is widely recognized as a need within all LHIN sub-regions.

Priority Description

The 2016-19 IHSP articulates how adequate support to live independently and safely is essential for vulnerable populations such as seniors, persons with physical disabilities and special needs, cognitive and/or developmental conditions, and individuals with serious mental health and/or addiction issues. The location and limited access to stable, affordable housing options with health supports, impacts the ability of patients to be discharged from hospital, and can lead to unnecessary dependence on hospital emergency departments as well as premature or unnecessary placement in long-term care homes. As such, housing is a key social driver of health and contributor to achieving the Central East LHIN vision, mission, and performance goals.

Current Status

The Central East LHIN has engaged with the five Consolidated Municipal Service Managers across the LHIN, namely the City of Peterborough (including the County of Peterborough), County of Northumberland (including the Town of Brighton), City of Kawartha Lakes (supporting Haliburton County), Durham Region, and City of Toronto (serving Scarborough) to collaboratively address the growing need for affordable housing with health supports. A Housing and Homelessness Framework and joint Strategic Aim guide LHIN and Municipal collaborations including the identification of common priorities; service level planning and opportunities to align and maximize new investments and existing funding to address needs in each sub-region.

Goals

- Improve access to high quality, timely, equitable services to support residents in securing and maintaining safe, affordable, and accessible housing with health and social support
- Promote health and social equity across populations and communities
- Make the best use of the public's investment

Consistency with Government Priorities

- *Housing Services Act* (2011)
- *Realizing Our Potential: Ontario's Poverty Reduction Strategy* (2014-2019)
- *Building Foundations: Building Futures, Ontario's Long-Term Affordable Housing Strategy* (2010, 2016)
- *A Place to Call Home: Report of the Expert Advisory Panel on Homelessness* (2015)

Action Plans

SUPPORTED LIVING ENVIRONMENTS							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status(%) complete		
					2017/18	2018/19	2019/20
LHIN Municipal Housing Partnership	- Sub-regions - Home and Community Care - Equity and Population Health - Community, Patient and Caregiver Engagement - Capacity Planning and ALC - Mental Health and Addictions - Innovation and Best Practice	- Finalize City of Toronto Housing Framework (Scarborough) - Identify further opportunities for alignment and investments resulting from Ontario's Long-term Affordable Housing Strategy in partnership with the five Consolidated Municipal Service Manager municipalities	- City of Toronto Housing Framework completed - Joint Plan for allocation of new resources resulting from the Long-term Affordable Housing Strategy	- Increased access to housing with supports	50	30	20
Rent Supplements	- Sub-regions - Home and Community Care - Equity and Population Health - Community, Patient and Caregiver Engagement - Capacity Planning and ALC - Mental Health and Addictions - Innovation and Best Practice	- Implement Year 3 of Mental Health Rent Supplement and Intensive Case Management allocations - Implement new Rent Supplements resulting from provincial Long-term Affordable Housing Strategy (2016/17) - Evaluation plan to be developed pending MOHLTC approval	- Year 3 Rent Supplement and Intensive Case Management allocations implemented - Evaluation plan completed	- Repeat ED visits for this client group reduced - Continuous QI based monitoring of implementation of Rent Supplements and attached Intensive Case management supports	80	20	0
Refer to Palliative Care Strategic Aim for additional initiatives related to Supportive Living Environments (Residential Hospice)							
Refer to Seniors Strategic Aim for additional initiatives related to Supportive Living Environments (Assisted Living for High Risk Seniors)							

Measuring Success

Metric	Reporting Level
Decrease in ALC days	Hospital
Number of new supportive housing units/people supported	LHIN/SR
Increased Shelter capacity (e.g. occupancy rate, number of beds)	LHIN/SR
Number of Coordinated Care Plans for complex vulnerable individuals	LHIN/SR
Number of homeless individuals as compiled by Municipal 'point in time counts'	LHIN/SR
Increase patients discharged home with the support they need	LHIN/SR/Hospital

Risk/barrier to Successful Implementation

- Coordination of multiple investment streams (i.e. MOHLTC health supports; Municipal Affairs and Housing)
- High demand and low vacancy rates for affordable housing in all sub-regions
- Complexity of client needs require access to and coordination of health and social services

Mitigation Strategies

- On-going planning and evaluation in partnership with Service Managers
- Initiation of Coordinated Care Plans for complex clients

HEALTH SYSTEM ENABLERS

Pursuing Quality and Safety through Effective Access & Transitions

Health Quality Ontario (HQO) has identified a primary focus of the advancement of quality. The Central East LHIN 2016-19 IHSP supports the advancement of quality of care ensuring safe, effective, efficient, timely and equitable access to care. Effective access and transitions are supported by monitoring and improving Ministry Local Health Integration Network Accountability Agreement (MLAA) performance indicators and targets.

Priority Description

In the 2017/18 ABP maintaining and improving wait times for key services continues to align with the MOHLTC's priority of improving public access to surgeries and procedures delivered to Ontarians by reducing wait times for key health services. Through the introduction of innovative models and collaboration between partners, wait time performance targets will be achieved through the close monitoring of patient demand, and ensuring volumes meet provider/community resource need.

Current Status

The Wait Time Strategy Working Group (WTSWG), in collaboration with the Health System Funding Reform Local Partnership (HSFR LP), continues to proactively discuss local implementation planning and change management. By identifying and discussing critical implementation issues and the associated strategies to ensure coordination across providers, the WTSWG continues to provide advice and strategies on volume management and performance. With a system and sub-regional lens, the WTSWG proactively engages and communicates with local providers across sectors, with emphasis on implementation planning and the impact on the health care system.

Goals

- Develop recommendations for an effective volume management strategy
- Advance innovative care models to increase accessibility to equitable care

Consistency with Government Priorities

- Emergency Department Pay for Results Program
- Critical Care Life and Limb Policy
- Ontario's Emergency Preparedness Planning and Policy
- Alternate Level of Care Strategy

Action Plans

PURSUING QUALITY AND SAFETY THROUGH EFFECTIVE ACCESS & TRANSITIONS							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status(%) complete		
					2017/18	2018/19	2019/20
Volume Management	- Performance Monitoring and Reporting - Capacity Planning and ALC	- Develop volume management strategies for Wait Time Strategy (WTS) opening volume allocations to ensure equitable distribution of volumes across the LHIN's seven sub-regions	- Volume management strategy	- Equitable access to care	50	25	25
Musculoskeletal (MSK) Incremental Volume Management	- Performance Monitoring and Reporting - Capacity Planning and ALC	- Work with providers to further reduce wait times and drive appropriate care utilization by establishing a centralized intake and assessment process	- Centralized intake and assessment process	- Increased access to care	70	30	0
Mood Disorders Volume Management	- Performance Monitoring and Reporting - Capacity Planning and ALC	- Work with providers to further reduce wait times and drive appropriate care utilization by establishing a centralized intake and assessment process	- Centralized intake and assessment process	- Increased access to care	70	30	0
Integrated Shoulder Care	- Sub-region - Equity and Population Health - Innovation and Best Practice	- Develop and implement a plan for Integrated shoulder care in the Central East LHIN - Support the development and sustainability of the Shoulder Centre model of integrated care	- Shoulder Centre established - Sustainability plan developed	- Increased access to specialist care	50	25	25

Measuring Success

Metric	Reporting Level
Percent of Priority II, III and IV Cases Completed within Access Target for Hip Replacement Surgery	LHIN/SR/Hospital
Percent of Priority II, III and IV Cases Completed within Access Target for Knee Replacement Surgery	LHIN/SR/Hospital
Percent of Priority II, III and IV Cases Completed within Access Target for Diagnostic MRI Scan	LHIN/SR/Hospital
Percent of Priority II, III and IV Cases Completed within Access Target Diagnostic CT Scan	LHIN/SR

Note: SR = LHIN sub-region

Risk/barrier to Successful Implementation

- Referral patterns, demand exceeding funded volumes, and patient choice/preferences
- Demand for MRIs has exceeded funded volumes and continues to increase
- Working with stakeholders to maximize throughput of MRI machines

Mitigation Strategies

- Develop a strong communication strategy with members of the Local Partnership and HSPs
- Continue data quality reviews and audits to ensure complete and accurate information is report

Key Enablers to achieve the Pursuing Quality and Safety Through Effective Access & Transitions

- Wait Times Strategy Working Group (WTSWG)
- Data quality initiatives
- Digital Health initiatives

System Design and Integration

A central mandate for all LHINs is to advance health system design and integration activities to improve the quality of client care, performance of the local health system, and system sustainability.

Priority Description

As identified in the 2016-19 IHSP, the Central East LHIN established Service and System Integration as one of its four strategic directions. It commits the Central East LHIN to work with all partners to integrate the health care delivery system to better meet the current and future needs of patients, caregivers and communities.

Current Status

In 2017/18, the LHIN will begin to lead the development of Clinical Services Plan 2.0 for hospital services in the Central East, which will include Master Planning and System Clinical Design.

Consistent with the Minister's direction to amalgamate the Centenary site of the Rouge Valley Health System (RVHS) and The Scarborough Hospital (TSH), and the asset transfer of the Ajax-Pickering site of the Rouge Valley Health System to Lakeridge Health (LH) in 2016/17, the Central East LHIN will work closely with the integrated hospitals throughout 2017/18 to undertake Master Planning. As part of the Master Planning process for the Scarborough and Durham Region hospitals, the Central East LHIN will work to bring a system perspective to the planning, sizing, siting, and standardization of programs and services needed by local communities over the next 30-year time horizon. The Central East LHIN will also support Scarborough and Rouge Hospital (SRH) as it takes the steps directed by the Minister to redevelop its Centenary Emergency Department in the near future.

The Central East LHIN will continue to support the Master Planning process for mental health services that began in 2016/17 at Ontario Shores Centre for Mental Health Sciences (OSMHS). As the Central East LHIN supports OSMHS to bring its proposal to the Board in mid-2017, staff will also begin to incorporate into their work Master Planning activities that are expected to begin in the Northeast Cluster later in the year.

Goals

- Continue to pursue achievement of the Central East LHIN overarching goal of advancing integrated systems of care
- Continue to drive collaboration and integration across the health care system through sub-region and regional planning
- Support innovative health technologies and processes through Digital Health initiatives

Consistency with Government Priorities

- *Excellent Care for All Act* (2010)
- *Patients First: Action Plan for Health Care* (February 2015)
- Integration as defined by the *Local Health System Integration Act* (2006)

Action Plans

SYSTEM DESIGN AND INTEGRATION							
Programs and Projects	Alignment with LHIN Mandate	Activities	2017/18 Outputs	2017/18 Outcomes	Status(%) complete		
					2017/18	2018/19	2019/20
Clinical Services Plan 2.0	- Provincial Priorities - Sub-regions - Primary Care - Home and Community Care - Equity and Population Health - Capacity Planning and ALC - Community, Patient and Caregiver Engagement - Innovation and Best Practice	- Develop Clinical Services Plan 2.0 in partnership with acute care hospitals and stakeholders	- Clinical Services Plan 2.0	- Better integrated system of care - Increased equitable access to acute care services and specialty services - Improved transitions for patients	50	50	0
Vision Care Strategy	- Sub-regions - Primary Care - Equity and Population Health - Innovation and Best Practice	- Establish a Vision Care Advisory Committee - Develop an implementation plan	- Vision Care Advisory Committee established - Implementation plan for the Vision Care Strategy Plan	- Increased quality of care - Access to quality care closer to home	50	25	25
Integrated Orthopaedic Capacity Plan (IOCP)	- Sub-regions - Equity and Population Health - Innovation and Best Practice	- Monitor the implementation of the cluster-specific IOCP Directional Plans	- IOCP Directional Plans implemented	- Increased access to care	0	0	100

Measuring Success

Metric	Reporting Level
Percentage of Alternate Level of Care (ALC) Days	LHIN/SR/Hospital
ALC Rate	LHIN/SR/Hospital

Note: SR = LHIN sub-region

Risk/barrier to Successful Implementation

- Lack of administrative and clinical leadership to support the development of the plans

Mitigation Strategies

- Leadership from LHIN clinical physician leads, governors and senior administrators

Key Enablers to Achieving the System Design and Integration System Enabler Priority

- Shared Communications, Engagement and Change Management Strategy

Enabling Technologies and Integration (DIGITAL HEALTH)

Digital health is the convergence of the digital and genomic revolutions with health, health care, living, and society that is empowering us to better track, manage, and improve the health of patients by reducing inefficiencies in health care delivery, improving access, reducing costs, increasing quality, and making the delivery of health care more personalized and precise.

Priority Description

Information technology and information management are key elements in connecting the various health care system sectors. Optimally, duplication is eliminated, allowing patients and family caregivers and service providers to share information and coordinate services quickly and efficiently as people transition through the care continuum.

Current Status

In 2017/18 the Central East LHIN will leverage information management and information technology investments made at the sub-region, system and provincial levels to enable health care transformation. Solutions implemented will be reflective of the Central East LHIN's IHSP strategic framework, and will be aligned to the MOHLTC's Digital Strategy recommendations and guidelines. They are also identified in the Central Ontario Cluster Enabling Technologies for Integration (ETI)

Business Plan. The current work of enabling technologies in the Central East LHIN include initiatives that are specific to health care sectors, cross sectors, specific health care professions, and align to the strategic directions of the Central East LHIN and the Central Ontario Electronic Health System Cluster (COEHSC).

Goals

- Build on the success of initiatives, developed through the ETI toolkit of the Central Ontario Cluster, based on the provincial priorities for ETI
- Support integration initiatives in ETI such as the Hospital Information System (HIS) strategy, and opportunities for shared services as per Digital Strategy recommendations
- Refresh of technology governance that includes the acute, community, and home sectors with linkages to the Health Links approach to care
- Develop more standardized and equitable funding for ETI initiatives based on criteria that includes prioritization and a qualitative evaluation through Expert Choice toolsets
- Work with local partners to leverage and support uptake of digital solutions to improve access and referrals to specialists
- Develop a roadmap that will create a better understanding of the technologies and systems developed in the region, and outline capacity for utilization and spread

Consistency with Government Priorities

- Technology to support patients to remain in their home, while minimizing emergency visits and readmissions to hospitals
- Technology that supports the coordinated care plan model for patients and providers
- Technology and data management that ensures the data quality and safety is maintained and protected
- Technology that allows patients to participate in decision making and their care
- The notification from the MOHLTC to the COEHSC group and the eHealth Leads in each LHIN that identify the ETI funding priorities, including:
 - Regional integration supporting connecting projects such as Connecting Ontario
 - Hospital Information Systems (HIS) support for collaboration and procurement as per Digital Strategy direction
 - Hospital Report Manager and eNotification implementation
 - Telemedicine and Telehomecare
 - Referral Management
 - CCT to support the Health Links approach to care
 - eConsult to provide primary care clinicians consult capacity to specialists
 -

Action Plans

ENABLING TECHNOLOGIES AND INTEGRATION (DIGITAL HEALTH)							
Programs and Projects	Alignment with LHIN Accountabilities	Activities	2017/18 Outputs	2017/18 Outcomes	Status(%) complete		
					2017/18	2018/19	2019/20
eNotification	- Provincial Priority - Primary Care - Digital Health - Innovation and Best Practice	- Project to enable CHRIS connectivity, on-board all hospitals - Adoption engagement and support for physicians to receive eNotifications	- # of alerts	- All hospitals sending eNotifications to Electronic Medical Records (EMR) through HRM (queue permitting)	90	10	0
Registry Integration with Common Electronic Regional Referral and Intake (CERRI)	- Provincial Priority - Primary Care - Home and Community Care - Digital Health - Innovation and Best Practice	- Work with eHealth Ontario to develop plan for integration to the provincial registry for clients and providers - Complete agreements for project funding	- Training information and support materials created - Access to Client Registry / Provider Registry from within CERRI for users to access/validate information - Evaluation and lessons learned	- Integration with CERRI for patient and provider provincial registry	75	25	0
CERRI (e-Referral Management)	- Provincial Priority - Primary Care - Home and Community Care - Digital Health - Innovation and Best Practice	- Full rollout of first three pathways - Design and planning for diagnostics - Readiness planning for next pathways - Integration with the STRATA referral system - Integration with up to three EMRs (EMRs to be	- Three pathways implemented - Readiness criteria for E-referrals pathways - Printable referral documents - Reporting on referrals, status, trends and success/failures of referrals	- Diagnostic pathway ready for implementation - Integration with STRATA¹ for bidirectional referrals for RM&R, rehab, and CCC (¹The STRATA referral system is a proprietary software system of Strata Health Solutions.)	40	60	0

ENABLING TECHNOLOGIES AND INTEGRATION (DIGITAL HEALTH)							
Programs and Projects	Alignment with LHIN Accountabilities	Activities	2017/18 Outputs	2017/18 Outcomes	Status(%) complete		
					2017/18	2018/19	2019/20
		determined)		- Integration with up to three EMRs for physicians to access CERRI from within their system and send electronically			
Connecting Ontario Expansion and Increased Adoption	- Provincial Priority - Primary Care - Home and Community Care - Digital Health - Innovation and Best Practice	- Wave 1- support early adoption and spread through Community of Practice - Wave 2- expansion to community viewing and other partners - Development of standards for the initiative - Multi-year implementation, go-live is expected late summer/early fall 2017/18.	- # of clinicians accessing aggregated patient information	- Informed decision making for treatment - Better care plans - Reduction of duplicate tests	10	55	35
CCT – Provincial Solution Spread and Adoption	- Primary Care - Home and Community Care - Digital Health - Innovation and Best Practice	- Support the Durham Northeast and Peterborough City and Peterborough County sub-regions currently using the provincial CCT - Develop implementation tools to onboard new organizations - Revise CCT cross-organizational utilization model and agreement	- Electronic Care Plans available to all sub-regions	- Implement the provincial CCT (pending approval) to be the tool for all sub-regions - Ability to improve the agreements and data sharing models to satisfy the participating organizations	50	30	20

ENABLING TECHNOLOGIES AND INTEGRATION (DIGITAL HEALTH)							
Programs and Projects	Alignment with LHIN Accountabilities	Activities	2017/18 Outputs	2017/18 Outcomes	Status(%) complete		
					2017/18	2018/19	2019/20
eConsult	- Provincial Priority - Primary Care - Home and Community - Innovation and Best Practice	- Adoption engagement and support for physicians to use eConsult	- # physicians registered - # consults sent	- Increased physician participation in the Provincial eConsult Project	40	30	30
CCT – CHRIS / Health partner Gateway (HPG) Interim Solution	- Home and Community Care - Digital Health - Innovation and Best Practice	- Participation in development of the interim CCT - Planning and development of governance, training, sustainable support model for implementation - Implementation of an interim CCT using the CHRIS/HPG - Evaluation and measurement process	- Electronic Care Plans available to all sub-regions by April 2017 - 1/5 implementations completed (Scarborough North)	- CCTs available to all providers participating in Health Links approach to care	15	60	25
Hospital Information System (HIS) Support -Procurement and Collaboration	- Provincial Priority - Innovation and Best Practice - Digital Health	- Expected Digital Strategy requirements released to help determine procurement and cluster implementation - Support for HIS cluster development and planning (RFP, governance, preparation) - Development and support for agreements	- Agreements established for cluster based governance - Procure RFP for cluster based HIS upgrade	- Decision on HIS procurement or upgrade for hospitals - Model of cluster based governance - Delay in MOHLTC providing guidelines	10	70	20
Ontario Laboratories Information System (OLIS)	- Primary Care - Home and Community Care - Digital Health	- Adoption engagement and support for physicians to use OLIS	- # clinicians subscribing	- Increase adoption and use of OLIS in clinical practice	40	30	30

ENABLING TECHNOLOGIES AND INTEGRATION (DIGITAL HEALTH)							
Programs and Projects	Alignment with LHIN Accountabilities	Activities	2017/18 Outputs	2017/18 Outcomes	Status(%) complete		
					2017/18	2018/19	2019/20
	- Innovation and Best Practice						
Electronic Medical Record (EMR) Adoption	- Primary Care - Innovation and Best Practice - Digital Health	- Identification of primary care providers without EMRs, or with EMRs not certified by OntarioMD ² - Engagement and support for physicians to implement OntarioMD ² certified EMRs	- Increased number of primary care providers using OntarioMD ² certified EMRs	- Increase adoption and use of EMRs in clinical practice	40	30	30
eCTAS - Electronic Canadian Triage and Acuity Scale	- Provincial Priority - Innovation and Best Practice - Access to Care - Equity - Population Health	- Implement electronic triage decision support system in all Central East LHIN hospitals	- eCTAS in all hospitals	- Improve patient safety and quality of care, ensuring patients are assigned an accurate CTAS level in a consistent manner	60	40	0

²OntarioMD is a wholly-owned subsidiary of the Ontario Medical Association.

Measuring Success

Metric	Reporting Level
Existing indicators for the IHSP Strategic Aims, and/or those used as part of service accountability	LHIN/SR/Hospital

Note: SR = LHIN sub-region

Risk/barrier to Successful Implementation

- Identifying and placing appropriate human resources to further support implementation
- Appropriately developed and adherence to the project plan timeline
- Engagement and adoption (pre- and post-implementation and sustainability) by users
- Achieving the outcomes and the desired improvement/reduction, etc.

Mitigation Strategies

- Ensure roles and responsibilities are correctly identified with stakeholder agreement
- Provide education to ensure understanding of processes, requirements, expectations, tools, etc.
- Regular reporting to project leadership to ensure all aware of issues / barriers that may change the schedule
- Develop communication plans that include the engagement strategy, materials for the stakeholders
- Review outcomes regularly during the initiative and complete an evaluation at the end of the initiative to evaluate the outcome against initial project goals

Key Enablers to Achieving the Enabling Technology and Integration System Enabler Priority

- Supporting structures developed that promote collaboration and no competition between organizations i.e. creation of more robust terms of reference
- Ensuring that appropriate measurement (including baselines) are identified, implemented, and evaluated throughout the initiatives
- Adherence to project management best practices to minimize issues, risks, and overruns to the schedule, costs, and outcomes

CENTRAL EAST LHIN OPERATIONS AND STAFFING

TABLE A – CENTRAL EAST LHIN OPERATIONS SPENDING PLAN

LHIN Operations (\$)	2016/17 Actuals	2017/18 Allocation	2018/19 Planned Expenses	2019/20 Planned Expenses
Operating Funding (excluding initiatives)	5,793,184	5,335,441	5,155,441	5,155,441
Initiatives Funding (including E-Health, A&MH, ED, Wait Time, etc.)	608,000	608,000	608,000	608,000
Salaries and Wages	3,885,142	4,279,462	4,099,462	4,099,462
Employee Benefits				
HOOPP	354,366	370,848	370,848	370,848
Other Benefits	484,895	484,895	484,895	484,895
Total Employee Benefits	839,261	855,743	855,743	855,743
Transportation and Communication				
Staff Travel	36,845	48,400	48,400	48,400
Governance Travel	19,663	15,000	15,000	15,000
Communications	57,491	40,000	40,000	40,000
Others				
Total Transportation and Communication	113,999	103,400	103,400	103,400
Services				
Accommodation	297,191	269,290	269,290	269,290
Community Engagement	19,842	20,000	20,000	20,000
Advertising	19,693	5000	5000	5000
Banking	426	5000	5000	5000
Consulting Fees	331,031	20,075	20,075	20,075
Equipment Fees	23,067			

LHIN Operations (\$)	2016/17 Actuals	2017/18 Allocation	2018/19 Planned Expenses	2019/20 Planned Expenses
Insurance	6,419	12,000	12,000	12,000
LSSO Shared Costs	367,379			
LHIN Collaborative	47,500			
Other Meeting Expenses	6,281	35,000	35,000	35,000
Board Chair's Per Diem Expenses	35,050	35,000	35,000	35,000
Other Board Members' Per Diem Expenses	50,675	65,000	65,000	65,000
Other Governance Costs	11,588	20,000	20,000	20,000
Printing and Translation	16,852	15,471	15,471	15,471
Staff Development	39,465	43,000	43,000	43,000
Other Services	93,551.25	93,000	93,000	93,000
Total Services	1,366,010	637,836	637,836	637,836
Supplies and Equipment				
IT Equipment	12,411	10,000	10,000	10,000
Office Supplies and Purchased Equipment	47,708	37,000	37,000	37,000
Other Supplies and Equipment	9,946	10,000	10,000	10,000
Total Supplies and Equipment	70,065	57,000	57,000	57,000
Capital Expenditures	46,247	10,000	10,000	10,000
LHIN Operations: Total Planned Expense	6,320,725	5,943,441	5,763,441	5,763,441
Annual Funding Target	6,401,184	5,943,441	5,763,441	5,763,441
Operating Surplus (Shortfall)	80,459			

LHIN Operations: Total Planned Expense	\$5,943,441.00
CCAC expenditure/allocation	\$313,252,224.00
Total LHIN and CCAC planned expense/allocation	\$319,195,665.00

Table B – Central East LHIN Staffing Plan (Full -time equivalents)

Central East LHIN Staffing Plan (Full-Time Equivalents)				
Position Title	2016/17 Actuals as of March 31, 2017 FTEs	Post Transition Day 2017/18 Forecast FTEs *add CCAC FTEs	2018/19 Forecast FTEs *add CCAC FTEs	2019/20 Forecast FTEs *add CCAC FTEs
CEO	1	1	1	1
Vice Presidents	0	4.6	4.6	4.6
Senior Director	2	0	0	0
Directors	5	22	22	22
Leads/(Senior)Managers/NP	4	62	62	62
Program Manager -eHealth	1	2	2	2
Managers/Consultants	9	*	*	*
Planner/Analyst (Senior)	6	40	40	40
Analyst	4	0	0	0
Coordinator – Care, Educators, Clinical	5	*	*	*
Administrative	5	*	*	*
*CCAC FTE subject to fluctuation		711	711	711
Total FTEs	42	902.60	902.60	902.60

The Operation and Staffing Plan were established based on the current operations of the Central East LHIN. The potential impact of health system transformation guided by further provincial direction on *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* will impact the Operations and Staffing plan in 2017/18

INTEGRATED COMMUNICATIONS STRATEGY

Business Objectives

The Central East LHIN's 2017/18 Annual Business Plan will operationalize the goals contained in the LHIN's 2016-2019 "Living Healthier At Home" IHSP, specifically:

- Advancing integrated systems of care to help Central East LHIN residents live healthier at home by:
 - Continuing to support frail older adults to live healthier at home by spending 20,000 fewer days in hospital and reducing Alternate Level of Care days for people age 75+ by 20% by 2019.
 - Continuing to improve the vascular health of people to live healthier at home by spending 6,000 fewer days in hospital and reducing hospital readmissions for vascular conditions by 11% by 2019.
 - Continuing to support people to achieve an optimal level of mental health and live healthier at home by spending 15,000 fewer days in hospital and reducing repeat unscheduled emergency department visits for reasons of mental health or addictions by 13% by 2019.
 - Continuing to support palliative patients to die at home by choice and spend 15,000 fewer days in hospital by increasing the number of people discharged home with support by 17% by 2019.

Communications Objectives

Given the changes to the health care system as a result of the passing of Patients First Act, 2016 and the changes that will be implemented as part of the Central East LHIN's 2016-2019 IHSP and the initiatives contained in this Annual Business Plan, the Central East LHIN and its Board will require a very deliberate approach to communication and engagement. A strong communications strategy and plan are critical to support the initiatives contained in this Annual Business Plan. The communication strategy and plan will need to:

- Ensure that the voice of patients and their caregivers is captured and reflected in the implementation of the initiatives and raising their awareness of health care services to support system navigation
- Continue to increase understanding among Central East residents and health care providers of the need for health system transformation specifically in the areas of seniors care, vascular health, mental health and addiction supports and palliative and end-of-life care
- Ensure that all stakeholders understand the role of the respective organizations to identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services based on funding available and tracking performance against signed accountability agreements
- Provide accurate and timely information to all audiences using materials that reflect the LHIN visual identity
- Build confidence among Ontarians that:
 - Progress is being made to improve access to health services
 - Progress is being made to improve the patient experience

- The system is sustainable, being effectively managed, providing value for tax dollars
- The system is transparent
- Increase health literacy to enable and support Ontarians to live healthy lives and manage their illnesses better.
- Engage patients, caregivers, providers, stakeholders and system leaders to become active participants in and ambassadors for transformation.

Context

- In the Central East LHIN, our “Living Healthier at Home” 2016-2019 IHSP and the initiatives laid out in this Annual Business Plan are strategically aligned with government direction and priorities and recognize the joint accountability of the MOHLTC and LHINs to serve the public interest and effectively oversee the use of public funds
- This includes achieving aims that will have a positive impact on seniors, people with mental health and addiction issues, people trying to improve their vascular health and individuals and their caregivers requiring palliative and end-of-life care
- Each LHIN is governed by a twelve-member Board of Directors made up of members from the local community. The board makes decisions about health services based on what is important to the community
- Through an agreement with the MOHLTC, each LHIN must measure how it is performing against a detailed list of requirements that includes looking at access to care and quality of care improvements
- LHINs work to ensure that every individual, regardless of gender, race, income or social status, has the same access to health care
- The benefits of LHINs are numerous and proven – they are able to build solutions around people and populations, to be flexible to allow for locally-driven solutions and to engage communities and individuals in health care design and delivery
- The health care system has evolved to the point where LHINs are being recognized as the local system managers who play a central leadership role in driving health system transformation

Target Audience

Depending on the situation, primary and secondary audiences will include:

- Patients/Clients/Service Users/Residents/Caregivers
- General Public:
 - Residents
 - Community Organizations
- Health Service Providers/Stakeholders (in all Central East sub-regions and surrounding LHINs):

- Health Service Providers Leadership and Front Line staff (including union leadership)
- Central East Health Service Provider Boards
- Physicians
- Consumer/Patient Support Groups
- Health care Associations (OHA, ONA, OMA, etc.)
- Government:
 - Municipal
 - Regional
 - Provincial – including MOHLTC stakeholders
 - Federal
- Central East LHIN Planning Partners
- LHIN staff and board members
- Local media
- Other LHINs
- Ministry of Health and Long-Term Care and other ministries as appropriate

Strategic Approach

- Position the enhanced Central East LHIN as a valued key player within the transformation of Ontario's health care system and as the lead in health system transformation in the Central East region
- Develop and leverage opportunities to build our reputation and establish credibility
- Provide accurate and timely information to all audiences
- Be transparent and accountable to our shared audiences re: timelines, outcomes and opportunity for participation/feedback
- Foster an understanding of the need for health system transformation both internally and externally
- Continue to build support for the health system model by focusing on the benefits of the health system transformation that creates an integrated sustainable health care system that ensures better health, better care, and better value for money

- Align the health service providers to the shared vision, mission, values and common “Living Healthier At Home” direction of advancing integrated systems of care to help Central East LHIN residents live healthier at home
- Demonstrate how patients/caregivers/general public can participate in improving their own health and support the development of plans to support care delivery in the seven LHIN sub-regions
- Mitigate communications risks of negative publicity by proactive planning of risk reduction
- Provide information on performance and progress on the implementation – document successes and share it
- Initiatives contained in the Annual Business Plan will have its own “Communications and Community Engagement Plan” (as required) documenting the context for each initiative, timelines, audiences, tools/tactics, specific key messages and a deliverables tracking chart. This will be a document that will be developed and rolled out in partnership with the appropriate health care partners and other stakeholders

Key Messages – Provincial

- The *Patients First: Action Plan for Health Care* is Ontario’s plan to transform the health care system into one that puts the needs of patients at its centre.
- The *Patients First: Action Plan for Health Care* sets clear and ambitious goals for Ontario’s health care system in order to put patients at the centre of our health care system by improving the health care experience: increasing access, connecting services, informing patients and protecting our health care system.
 - We have made progress in all four priority areas, but we can do more to put patients first.
- By putting patients first in everything we do, we will provide faster access to the care patients need today and make the necessary investments to ensure our health system will be there for patients for generations to come.
- On December 7, 2016, Ontario passed the Patients First Act, 2016, an important step forward in the *Patients First: Action Plan for Health Care*.
- Once fully implemented, changes supported by the Patients First Act will make local health care more responsive to local needs:
 - Patients will benefit from improved access to primary care, including a single number to call when they need health information or advice on where to find a new family doctor or nurse practitioner.
 - Primary care providers, inter-professional health care teams, hospitals, public health units and home and community care providers will be better able to communicate and share information, to ensure a smoother patient experience and transitions. Our goal is that patients will only have to tell their story once.
 - Administration of the health care system will be streamlined and reduced, with savings put back into improving patient care.
 - The voices of patients and families in their own health care planning will be strengthened.
 - There will be an increased focus on cultural sensitivity and the delivery of health care services to Indigenous peoples and French speaking people in Ontario.

- LHINs will ensure that any changes are seamless and that they simplify and improve patient experience. There will be no added bureaucracy and financial savings will go to patient care.

Key Messages – Local

- The Central East LHIN is a key partner in transforming the health system to provide quality care that meets the needs of Ontarians today and into the future
- Current fiscal realities and demographic trends have created a need for transformation
- We are working with our partners, including our Patient and Family Advisory Committee (PFAC), Primary Care and Public Health, to change from an old system designed to treat people once they are sick to a more coordinated, value-driven model that promotes wellness, and is patient focused
- Populations are growing and aging. The rates of chronic conditions are rising. To respond, the LHIN is working with our partners in each of our seven sub-regions to address these realities and develop innovative solutions to keep Central East LHIN residents healthy
- LHINs have already brought about significant and positive change in the way health services are delivered, and we must continue that work. In fact, we must aggressively build upon that work, because the status quo is neither acceptable nor sustainable
- Transformation requires a collective call to action
- Everyone has an important role to play in making healthy change happen, including health service providers, patients/families and caregivers, the LHINs, public health, primary care providers, community leaders and the public
- Since its inception, the Central East LHIN has recognized the value of listening to the voice of patients and their family caregivers. Taking action on the lived experience of patients and their caregivers resulted in the establishment of new programs, improvements to existing services and when warranted, the re-design or re-assignment of accountability of services. Effectively engaging with patients and caregivers, supported by the Central East LHIN PFAC, will be an ongoing area of focus in 2017/18
- Patients and caregivers need to become more accountable for their own health and actively participate in the development of plans that support care delivery in the seven LHIN sub-regions

High Level Tactics

The Communication team leverages a variety of communication vehicles tailored to various stakeholder groups. Specific tactics will be referenced in each plan which will include:

- News releases/Blast Emails/Newsletters/Bulletins/Videos;
- Printed collateral including brochures, information booklets, display materials for patients and caregivers;
- Website postings/alerts/social media;
- Stakeholder events;

- Outreach to local government stakeholders; and
- Engagement with specific stakeholders – unions, provincial associations, community groups.

Evaluation

Identifying and tracking critical communication success factors will enable the Central East LHIN to more effectively identify whether communication activities have been successful.

- Visible senior leadership engagement and support of the ABP initiatives and related communications through inclusion of stakeholders involved in the development/implementation or receipt of positive initiatives and outcomes in public communication materials and engagement events.
- Senior leadership, LHIN-wide and sub-region committees take visible, active roles in supporting communications and change with their teams as tracked in shared communication and community engagement plans.
- Evaluate engagement of stakeholders across the Central East LHIN – are they engaged early and frequently and how is their participation impacting the implementation of the future state?
- Evaluate Central East LHIN citizens' engagement by monitoring and measuring tone and volume of traditional media, online/social media (e.g., websites, Twitter, Facebook) and LHIN communication vehicles (blast emails, bulletins).
- Evaluate participation in public engagement activities including town halls, focus groups, paper and web-based surveys.
- Feedback mechanisms and ongoing assessment are in place to monitor the effectiveness of communication vehicles and messages, and the LHIN has the ability to make quick modifications based on shifts and lessons learned as activities are carried out.

COMMUNITY ENGAGEMENT

In accordance with Community Engagement Guidelines (Revised June 2016) and in keeping with the expectations of the Local Health System Integration Act (LHSIA 2006), all LHINs are required to develop and publish their Community Engagement plan. Plans are updated annually to reflect specific priorities and objectives in the current/upcoming year.

The Central East LHIN's Community Engagement Plan provides an overview of the priority activities and associated community engagement mechanisms or strategies that will support achievement of the initiatives contained within this Annual Business Plan.

Guided by the organization's vision "Engaged Communities – Healthy Communities" and focused on achieving its identified priorities in 2017/18, the Central East LHIN will fulfill its commitment to community engagement in the following ways:

Engagement Strategies and Best Practices

A variety of best practice strategies, appropriate to the desired objectives and identified level of engagement will be employed. The objectives of community engagement will be identified in advance for priority initiatives and will vary across the following engagement continuum.

Inform and Educate: To provide accurate, timely, relevant and easy to understand information to the community. This level of engagement will provide information about the LHIN, and offers opportunities for community members to understand the problems, alternatives and/or solutions. There is no potential to influence final outcome as this is one-way communication.

Gather Input: To obtain feedback on analysis and proposed changes. This level of engagement provides opportunities for community to voice their opinions, express their concerns, and identify modifications. There may be potential to influence the final outcome.

Consult: To seek out and receive the views of community stakeholders on policies, programs or services that affect them directly or in which they may have a significant interest. This level provides opportunities for dialogue between community and the LHIN. Consultation may result in changes to the final outcome.

Involve: To work directly with stakeholders to ensure that their issues and concerns are consistently understood and considered, and to enable residents and communities to raise their own issues. In this level, community stakeholders may provide direct advice as this is a two-way communication process. This level will influence the final outcome and encourage participants to take responsibility for solutions.

Collaborate: To work with and enable stakeholders to work through options/solutions to find common ground or agreement.

Empower: Delegated stakeholder decision making where final decision making authority, leading to action is assigned to a committee (ad hoc, standing) or other organized body (project-related work group or task).

Identification of Stakeholders & Assessment of Impact and Outcomes

The Central East LHIN is committed to leverage the knowledge, experience and expertise that currently exists within Central East LHIN communities (LHIN sub-regions) to achieve its objectives. Accordingly, a core principle of engagement in Central East LHIN is to identify existing stakeholder groups or entities, individuals or organizations which have interest in the outcomes of the initiative/project.

Stakeholders are individuals, communities, political entities or organizations that have a vested interest in the outcomes of the initiative. They are either affected by, or can have an effect on, the project. Anyone whose interests may be positively or negatively impacted by an initiative or anyone that may exert influence over the initiative or its results is considered a project stakeholder. All stakeholders must be identified and managed/involved appropriately. For the purpose of stakeholder identification, “communities” can be interpreted to mean geographic locations (i.e. a municipality in the Central East LHIN region), communities of interest or communities of practice.

Community of interest (COI) - an informal, self-organized, network of individuals brought together around a common interest, issue, concern or opportunity. They need not meet physically and may only ever connect with one another on an ad hoc basis, around that common element.

Community of practice (CoP) - an Informal, self-organized, network of peers with a common area of practice or profession. Such groups are held together by the members' desire to help others (by sharing information) and the need to advance their own knowledge (by learning from others).

Political Entity - For the purpose of stakeholder identification, “political entity” is an individual, organization or group with known political interests or public responsibility. This may include officials in public office, or organized labour or citizens groups.

Planning Partners – for the Central East LHIN, Planning Partners is defined as a group that has been formally constituted and/or is supported by the LHIN in order to facilitate engagement related to LHIN MLAA deliverables.

To further support the identification of stakeholder entities/groups the Central East LHIN maintains and updates a stakeholder engagement matrix, which at the present time includes, but is not limited to the following Planning Partners:

- BSO Design Teams
- BSO Education Committee
- CCDC Diabetes Committee
- Central East Centralized Diabetes Intake and Referral Steering Committee
- Central East Diabetes Network
- Central East Emergency Care Steering Committee
- Central East Executive Council
- Central East LHIN Communications Network
- Central East LHIN Communications Sub-Committee
- Central East LHIN Critical Care Network
- Central East LHIN Diagnostic Imaging Working Group
- Central East LHIN Patient and Family Advisory Committee
- Central East LHIN Regional Decision Support Working Group
- Central East LHIN Self-Management Program Advisory Council
- Central East LHIN Wait Time Strategy Working Group
- Central East Maternal, Neonatal and Paediatric Committee
- Central East Medical Assistance in Dying (MAID) Working Group
- Central East Mental Health and Addictions Coordinating Council
- Central East Regional Palliative Care Steering Committee
- Central East Regional Quality Committee
- Central East Seniors Care Network
- Central East Vascular Surgery Regional Services Steering Committee
- Child and Adolescent Mental Health Advisory Group
- Clinical Vice Presidents and Chief Nursing Officers from Central East LHIN Hospitals
- Coalition for Healthy Francophone Communities – Scarborough
- Durham Governance Advisory Council
- Durham North East Health Link Steering Committee
- Durham North East Health Link Design Team
- Durham North East Health Link Quality Improvement Team
- Durham West Health Link Steering Committee
- eHealth Steering Committee
- First Nations Health Advisory Circle
- Francophone Community Table on Health – Durham Region
- French Language Health Planning Entity (Entite 4)
- Geriatric Assessment Intervention Network (GAIN) Operating Committee
- Haliburton County, City of Kawartha Lakes Health Links Steering/Design Committee
- Haliburton County, City of Kawartha Lakes Health Links Quality Improvement Team
- Health Professionals Advisory Committee (HPAC)
- Home First Sustainability Steering Committee
- Financial Leadership Group
- HSFR Local Partnership Table
- Medical Leadership Group - Chiefs of Staff from Central East LHIN Hospitals

- Métis, Inuit, Indigenous People's Advisory Committee
- Northeast Governance Advisory Council
- Northumberland County Health Link Steering/Design Committee
- Northumberland County Health Link Quality Improvement Team
- Peterborough City and County Health Link Steering Committee
- Peterborough City and County Health Link Design Team
- Primary Health Care Advisory Group
- Sub-region Planning Tables
- Scarborough (South and North) Health Link Steering Committee
- Scarborough (South and North) Health Link Design Team
- Scarborough (South and North) Health Link Quality Improvement Team
- Scarborough Governance Advisory Council
- System Surge Management – Emergency Management Leads
- Telehomecare Steering Committee
- Vascular Health Strategic Aim Coalition (Cardiac Services Steering Committee)

The assembly of new Central East LHIN Planning Partner tables, project teams and work or task groups and ongoing support for existing tables, project teams, and work or task groups involves the identification of key stakeholder perspectives such as community, hospital, consumer/caregiver, clinical or administrative/leadership.

As appropriate, the engagement of providers or persons with expertise and experience in the delivery of services from across the three service clusters and sub-regions within the Central East LHIN is also obtained namely, the Northeast (Northumberland County, Haliburton County and City of Kawartha Lakes, Peterborough City and County), Durham (Durham West, Durham North East) and Scarborough (Scarborough North, Scarborough South).

Engagement of Indigenous Peoples

The Central East LHIN estimates that the First Nation, Métis and urban-based Indigenous peoples residing in the region represents about one percent of the total regional population. First Nation, Metis, Inuit and Non-Status people face a number of health issues and challenges and their health status is below that of the general population. First Nation, Metis, Inuit and Non-Status people have identified a number of barriers to receiving equitable access to health services including jurisdictional issues, lack of sensitivity to their culture, and a lack of targeted programs that focus on their particular health needs.

One of the main goals of the Central East LHIN is to continue to work with the First Nation, Metis, Inuit and Non-Status peoples to improve their overall health status. The Central East LHIN is committed to working with all Indigenous people to align health services with existing regional, provincial and federal health planning, health programming and service delivery systems to improve health outcomes.

The Alderville First Nation, Curve Lake First Nation, Hiawatha First Nation, Métis Nation of Ontario, Mississaugas of Scugog Island First Nation and the Central East LHIN have established a significant partnership that benefits the health, communities and the future of First Nations, Metis, Inuit and Non-Status people.

Through two advisory groups - the First Nations Health Advisory Circle and the Métis, Inuit, Non-Status People's Advisory Committee, the Central East LHIN receives advice on a variety of topics reflecting on provincial and Central East LHIN priorities pertaining to the Indigenous people represented.

Engagement of Central East LHIN Francophone Community

The Central East LHIN has a French-speaking population of approximately 32,400 or 2.3% of the population (2006). Almost 80% of the LHIN's Francophone population lives in Scarborough and Durham West/East. In the Central East LHIN, only Scarborough is officially designated under the French Language Services Act (FLSA).

The Central East LHIN's commitment to equity and respect for diversity recognizes the requirements of the FLSA and the legislation pertaining to the Engagement with the Francophone Community (January 2010) in serving Ontario's French-speaking community.

To do so, the Central East LHIN engages with its Francophone community in partnership with the French Language Planning Entities (April 2011). FLS Entity #4 for Central East LHIN provides advice and support to the Central East LHIN with respect to:

- Engaging the local Francophone community
- Identification and planning for health needs and priorities
- The needs and priorities of diverse groups within the Francophone community
- Health services available to the Francophone community
- The identification and designation of health service providers for the provision of French language health services
- Strategies to improve access to, accessibility of and integration of French language health services in the local health system
- The integration of French language health services

Conclusion

The action plans and specific business, communication and community engagement activities contained in the Central East LHIN's 2017/18 Annual Business Plan will support the health system transformation goals outlined in the *Patients First Act, 2016*. The Central East LHIN will continue to lead ongoing transition and transformation activities across its seven sub-regions to support the sustainability of our health care system. Together with our many partners, including Primary Care, Public Health, the Francophone Entity and Indigenous Circles, we will continue to engage, innovate and implement so that we keep people healthy and well in the community.

APPENDIX – PROGRAM DESCRIPTIONS:

Seniors Aim

Long-Term Care Home Redevelopment: under the *Enhanced Long-Term Care Home Renewal Strategy*, the province will help long-term care home (LTCH) operators redevelop older homes to bring them up to the highest design standards.

Memory Services: a primary care-based regional memory services program that enhances the capacity for timely detection, diagnosis, and treatment of memory problems and dementia.

Adult Day Programs (ADPs): a core feature of the comprehensive system of care for at-risk seniors and their caregivers living in the community, is providing activation for patients, relief to family caregivers. Provided in a congregate setting, services include social activities, meals, and health care assistance.

Assisted Living Services for High Risk Seniors (ALS-HRS): service hubs address needs of high risk seniors to support living at home, including scheduled and non-scheduled personal support, homemaking, security checks, and 24/7 reassurance services.

Assess and Restore (A&R): a targeted MOHLTC initiative provides funding each year between 2014 and 2017 (2017/18 funding currently is in the planning stages with the Ministry) on a one-time basis to enhance timely and appropriate access to facility-based A&R interventions, appropriate capacity across all the elements of an A&R approach to care, and quality of care through the development and dissemination of standards and best practices. This work extends the functional independence of frail older adults and reduces the burden on caregivers.

Seniors: Through the annual Joint Action Plan between Entité 4 and Central East LHIN partners, there have been accomplishments in advancing access to services in French for seniors including: development of a francophone Adult Day Program, Seniors' Wellness Symposium, optimizing bed occupancy in

francophone LTCH (Bendale Acres), and promotion of health care services available to seniors in French.

Vascular Aim

The Ontario Telemedicine Network (OTN) Telewound Care Project: In November 2016, the Central East Community Care Access Centre (CECCAC) with support from the Central East LHIN submitted a proposal to the Ontario Telemedicine Network (OTN). This submission was in response to a provincial Expression of Interest (EOI) for a Telewound Care Project. The goal of the Telewound Care Project is to improve patient outcomes, patient/caregiver experience and reduce overall costs for managing wound care, which can be a lengthy process. Through this initiative OTN based technologies will be utilized, and clinical care pathways that include this technology will be developed to optimize wound care. The project targets patients suffering from complex chronic and acute wounds and patients who rely on treatment from community care service providers to maintain a regular quality of life. The Central East CCAC was one of three CCAC's provincially that was selected in December 2016 to participate in this initiative.

OTN Telehomecare: a time-limited intervention (about six months), which provides in-home monitoring for clients through technology. This remote monitoring is supported by a registered health care provider (registered nurse or respiratory therapist) with specialized training in coaching and self-management. Initial areas of applicability include frail seniors enrolled in the GAIN program, Chronic Disease Secondary Prevention program, Chronic Obstructive Pulmonary Disease (COPD)/Congestive Heart Failure (CHF) initiatives and DEPs.

Stroke Strategy: intended to improve performance, increase access to care, and reduce practice variation. Stakeholders are engaged in establishing a system of coordinated stroke services for equitable access to quality-based

procedures and emerging stroke best practice, and to support collaboration and consistency across the Central East LHIN.

Diabetes Education Programs (DEP): there are thirteen adult DEPs and two paediatric DEPs providing community, needs-based education and management services.

Self-Management: for patients, caregivers, and HSPs, provides workshops to empower people to live well while dealing with conditions including diabetes, heart disease, arthritis, lung disease, and other chronic health issues.

(Please refer to *Health Equity Direct Care Priority* for specific Francophone and Indigenous initiatives related to Self-Management)

Regional Cardiovascular Rehabilitation and Secondary Prevention (CRSP): provides regional integrated service utilizing referral criteria, centralized referral, acceptance and booking for patients with vascular disease (including those with diabetes, chronic renal disease, stroke, cardiac disease, congestive heart failure, and peripheral vascular disease) at high risk for cardiovascular complications.

Rehabilitation Capacity Planning: development of a region-wide plan for sub-acute health services in an effort to establish a framework to support capacity planning for rehabilitative care. The goal is to develop a region-wide plan to guide the Central East LHIN in its planning and implementation of programming and services that allow timely access to sub-acute care and optimize patient outcomes.

Mental Health and Addictions Aim

Assertive Community Treatment Teams (ACTT) Together Project: based on Quality Improvement (QI) principles, the ACTT Together Project has identified and implemented several improvements within the approved ACTT model.

Child and Adolescent Hospital-Based Psychiatric Services Project: The objective of this project is to develop and implement recommendations regarding the future state of child and adolescent hospital-based mental health services in the Central East LHIN. The Central East LHIN is overseeing the

implementation of system level improvements that will standardize these services across the region.

Mental Health and Addictions Scan: This project is the first step in the development of a Mental Health and Addictions Strategy for the Central East LHIN. Deloitte has been retained, via an Expression of Interest process, to carry out a system wide scan of the current state of the Central East LHIN Mental Health and Addictions system. The scan will identify the current gaps and opportunities and the effect of investments and improvements made thus far.

Dual Diagnoses Framework: a framework mandated by the Ministry of Health and Long-Term Care, the Central East LHIN is considering how to ensure access to health care services for people with developmental disabilities. The LHIN is committed to implementing the updated Dual Diagnosis Framework once it is finalized and released by the Ministry.

Palliative Aim

Community Palliative Care for Vulnerable and Underserved

Populations: The development of a proposal to improve access to hospice palliative care for the homeless population in Central East LHIN. The model focuses on partnerships with health and social service providers.

Medical Assistance in Dying (MAID): On February 6, 2015 the Supreme Court of Canada released its decision regarding physician-assisted dying in *Carter v. Canada*. This decision commonly referred to as the 'Carter decision' declared that sections of the Criminal Code, which prohibit a physician's assistance in terminating life, infringe upon the right to life, liberty and security of the person for individuals who want access to physician-assisted death. On June 17, 2016 Federal Bill C-14 (Medical Assistance in Dying) received Royal Assent. To plan for integrated, informed, connected, patient-centred provision of MAID across the Region, the Central East LHIN MAID Working Group was established. The Working Group is developing a regional plan that promotes equity and access for all persons in any organization in the Central East LHIN. As MAID is an end-of-life care option, collaborative planning for MAID and palliative care is necessary.

Palliative Care Community Teams: interdisciplinary team-based models providing clinical and non-clinical community-based care to palliative and end-of-life patients. Teams focus on providing holistic care addressing physical, psychological, social, spiritual, and practical issues and associated expectations, needs, hopes, and fears. Partners include hospice services, hospital, CCAC, family health teams, community health centres, physicians, and community support services.

Residential Hospice Services: Targeted planning opportunities in each cluster aimed at supporting the development of residential hospice services in the Central East LHIN, offering an appropriate model of end-of-life care that is at varying levels of development.

Hospital-Based Initiatives

Integrated Shoulder Care: To sustain and build on the success of The Shoulder Centre proof-of-concept model to provide and improve access to care to patients requiring non-surgical and surgical interventions for shoulder complaints. The integrated model of care includes: centralized access within primary care (intelligent e-Referral) that reviews and triages to the most appropriate team member; primary care champions to manage minor to moderate complexity shoulder complaints, more complex cases referred to the Shoulder Centre Hub; and a Memorandum of Understanding between the primary care providers and The Shoulder Centre to utilize the standardized intelligent e-Referral and not to order MRIs. The Shoulder Centre agrees to assess 90% of referred patients within 4 weeks and to provide specialized training and education to primary care providers and shoulder champions.

Integrated Orthopaedic Capacity Plan (IOCP): in response to a MOHLTC request, the Central East LHIN initiated a comprehensive orthopaedic and musculoskeletal planning process for a regional system of orthopaedic care from pre-operative education and intake to community-based rehabilitation for all orthopaedic procedures. This work will continue and with objective being to enhance access to Musculoskeletal (MSK) services.

The IOCP was developed by working groups made up of representatives from a variety of Central East LHIN HSPs. The IOCP Key System Changes have been reviewed and prioritized by cluster-based Orthopaedic Planning and

Implementation Committees (OPICs). The OPICs for each of the three clusters (North East, Durham, and Scarborough) developed Directional Plans and Project Charters outlining the plan for implementing the Key System Changes.

Digital Health

Common Electronic Regional Referral and Intake (CERRI): phase I of this initiative will develop three clinical pathways and the oversight structure. This will serve as the initial test for future pathways: acute to inpatient rehabilitation/Complex Continuing Care; Diabetes; CRSP.

Connecting Ontario: connecting three regional electronic patient health record initiatives (connecting GTA; Central Ontario, South Western Ontario, and North and Eastern Ontario) that leverages local, regional, and provincial assets. Early adopters in the Central East LHIN include Lakeridge Health, The Scarborough Rouge Hospital, the Central East CCAC, and two long-term care facilities.

CCT – Provincial Solution Spread and Adoption: piloted in two sub-regions in the Central East LHIN in 2015/16, the intent is to continue to spread the use of this tool within all sub-regions.

CCT – Interim Solution: with approval to develop enhancements to the existing CCT in the Clinical Health Record Information System (CHRIS) system, the initiative will provide the Central East LHIN sub-regions an interim opportunity to better support their care planning and coordination for complex patients.

Hospital Information System (HIS) Visioning: requested by the Central East LHIN Board of Directors, the development of a current state, environmental scan, and principles that could support a broader unified vision of hospital technology systems. This has been utilized in the acute sector in their planning and also in the Digital Strategy work in the MOHLTC to inform and support their development of recommendations to the acute sector in the province.

Glossary of Acronyms

Acronym	Full Name
A&R	Assess and Restore
ABP	Annual Business Plan
ACTT	Assertive Community Treatment Teams
ADP	Adult Day Program
ALC	Alternate Level of Care
ALS-HRS	Assisted Living Services for High Risk Seniors
BSO	Behavioural Supports Ontario
CCAC	Community Care Access Centre
CCDC	Centre for Complex Diabetes Care
CECCAC	Central East Community Care Access Centre
Central East LHIN	Central East Local Health Integration Network
CEPC	Central East Primary Care
CERRI	Common Electronic Regional Referral and Intake
CHF	Congestive Heart Failure
CHRIS	Clinical Health Record Information System
CMG	Case Mix Group
COEHSC	Central Ontario Electronic Health System Cluster
COPD	Chronic Obstructive Pulmonary Disease
CRSP	Cardiovascular Rehabilitation and Secondary Prevention
CTAS	Canadian Triage and Acuity Scale

Acronym	Full Name
DD	Dual Diagnosis
DEP	Diabetes Education Program
ED	Emergency Department
EMR	Electronic Medical Record
ETI	Enabling Technology and Integration
FLS	French Language Services
FLSA	French Language Services Act
GAIN	Geriatric Assessment Intervention Network
HCC	Home and Community Care
HIS	Health Information System
HPAC	Health Professionals Advisory Committee
HPG	Health Partner Gateway
HQO	Health Quality Ontario
HRM	Hospital Report Manager
HSFR	Health System Funding Reform
HSFR LP	Health System Funding Reform Local Partnership
HSP	Health Service Providers
IHI	Institute for Healthcare Improvement
IHSP	Integrated Health Service Plan
IOCP	Integrated Orthopaedic Capacity Plan
LHIN	Local Health Integration Network
LHSIA	Local Health System Integration Act
LTCH	Long Term Care Home

Acronym	Full Name
MLAA	Ministry of Health and Long-Term Care/LHINs Accountability Agreement
MOHLTC	Ministry of Health and Long-Term Care
MRI	Magnetic Resonance Imaging
OHA	Ontario Hospital Association
OIVHS	Ontario Integrated Vascular Health Strategy
OMA	Ontario Medical Association
ONA	Ontario Nurses' Association
OPCN	Ontario Palliative Care Network
OPIC	Orthopaedic Planning and Implementation Committees
OTN	Ontario Telemedicine Network
PC	Primary Care
PCCT	Palliative Care Community Teams
PFAC	Patient and Family Advisory Council
PHCAG	Primary Health Care Advisory Group
PSS	Personal Support Services
QI	Quality Improvement
RFP	Request for Proposals
RM&R	Resource Matching and Referral
SR	Sub-region
WTS	Wait Time Strategy
WTSWG	Wait Time Strategy Working Group