Waterloo Wellington **LHIN**

Annual Business Plan
2011 - 2012 to 2013 - 2014

Ontario
Waterloo Wellington Local Health Integration Network

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Introduction

The Waterloo Wellington Local Health Integration Network's (WWLHIN) Annual Business Plan (ABP) is the document that translates Working Together for a Healthy Future, Integrated Health Service Plan (IHSP), 2010- 2013 into action. The IHSP, 2010 - 2013 is the three-year strategic plan for Waterloo Wellington's health care system. It calls for collaborative work that will see the WWLHIN, health service provider organizations, networks, and local residents come together to create a system that enables everyone to "Live and Live Well in Waterloo Wellington."

The Annual Business Plan is the action plan for the eight priorities identified in the IHSP, 2010 - 2013. The Plan outlines how we are going to implement the system improvement initiatives for each of the priorities, and how we will measure our achievements to track our progress. This Plan builds on previous successes and identifies new opportunities. It also outlines which organizations and networks are accountable for delivering the priority initiatives.

The local action plan demonstrates that the Waterloo Wellington priorities are aligned with the provincial direction and acknowledges targets set in the Ministry-LHIN Accountability Agreement (MLAA). The WWLHIN ABP supports the overall vision of the province to have a patient / client focused, results based, and sustainable health system. Four of the five identified provincial focus areas are identified within the eight WWLHIN priorities. They are:

- improve access to emergency department (ED) care
- decrease alternate level of care (ALC) days
- support the implementation of Ontario's diabetes strategy
- enhance addictions and mental health services.

The fifth provincial focus area builds on the existing eHealth framework and is identified as one of the three enablers by the WWLHIN to support the implementation of the priorities.

Through the implementation of the Annual Business Plan, the WWLHIN and health service providers can focus their collective efforts on addressing the issues identified by our communities, which are organizational efficiency, long-term sustainability, outcomes and results.

Context

Mandate:

The Waterloo Wellington Local Health Integration Network is responsible for planning, coordinating, integrating and funding health services in Waterloo Region, Wellington County, including the City of Guelph, and South Grey County.

Recognizing the role of health care in the Waterloo Wellington community, the WWLHIN, in consultation with the community, developed the following mission:

Inspiring people to improve quality of life now and in the future through collaborative relationships and health system integration.

The WWLHIN's vision is the same as the Ministry of Health and Long-Term Care (MOHTLC).

A health care system that helps people stay healthy, delivers good care to them when they get sick and will be there for their children and grandchildren.

The MOHLTC's vision provides a common direction for the LHINs and all health service providers in Ontario. The vision was reconfirmed as part of the community engagement consultations for the IHSP, 2010 - 2013.

In addition to the mission and vision, which define what our role is in the Waterloo Wellington community, the WWLHIN values guide how we do our work.

Accountability - Follow through, evidence-based outcomes and transparency

Integrity - Sound decision making processes and honesty

Innovation - Creativity, future focus and change

Community - Respect, engagement and focus on people

Strategic dimensions are key focus areas that will help advance the vision for the WWLHIN health system. They define the building blocks to enhancing the quality of the health care system. As part of the development of the IHSP, 2007 - 2010, the WWLHIN, with input from the community, identified these four strategic dimensions, and they remain relevant today.

- improve access to health services
- improve the health of the population
- enhance system effectiveness
- build capacity to achieve a sustainable health care system.

In addition to the strategic dimensions, three areas have been identified as being vital enablers that will facilitate the achievement of system improvement and transformation; they are eHealth, health human resources, and strategic leadership.

Based on the WWLHIN's mission, vision, values and strategic dimensions, an integrated health system for Waterloo Wellington means:

> A system that is easy to use and access, is coordinated and effective, promotes health and wellness, ensures the highest quality of care and services, recognizes and leverages the contributions of all stakeholders, encourages innovation, partnership and excellence and will be there for us today and tomorrow.

Overview of the WWLHIN's IHSP:

The WWLHIN undertook an extensive community consultation process from January - October 2009, to develop the plan to improve the local health system, *Working Together for a Healthier Future, Integrated Health Service Plan, 2010 - 2013.* The IHSP, 2010 - 2013 lays the foundation to transform the local health system to the envisioned integrated system. Health system providers and other partners were engaged to identify specific system improvement initiatives in each of the three years of the IHSP. The improvement initiatives form the basis of this 2011 - 2012 Annual Business Plan.

The IHSP, 2010 - 2013 focuses on the following eight priorities:

- Improving patient safety and enhancing quality of care
- Improving wait times for MRI exams
- Improving access to emergency department (ED) care
- Improving access to primary care
- Improving access to, and coordination of, addictions and mental health services
- Improving chronic disease prevention and management (including diabetes)
- Improving outcomes for stroke patients through integrated programs
- Decreasing alternate level of care (ALC) days.

Environmental Scan of Opportunities and Risks /Assessment of Issues:

As part of the WWLHIN's IHSP, a thorough environmental scan was undertaken. While the information and the resultant LHIN priorities still hold true, much has been learned about the interaction between these priorities and the order in which work must be undertaken to successfully transform the health system.

While progress has been made on many of the WWLHIN priorities and overall system performance has been steadily improving, emergency department (ED) wait times have remained an ongoing challenge. Likewise, and not unrelated, are wait times for patients in acute and post-acute hospital beds, who no longer require the intensity of resources or services provided in those care settings (Acute, Complex Continuing Care, Mental Health or Rehabilitation), and who are waiting for alternate level of care (ALC).

Long ED wait times and high ALC days are both indicators of larger issues in the health system. When residents are unable to get the care they need, when and where they need it, they will seek help wherever they can, often turning to the ED. Likewise, when patients are unable to be discharged from hospital beds to a more appropriate setting due to process delays, lack of available services or poor coordination or utilization of available services, they occupy beds that are needed by other patients, many of whom will now have to wait longer in the ED.

Recognizing that both ED wait times and ALC days are sentinel indicators of system quality, the WWLHIN has prioritized its planned strategic initiatives to focus first on initiatives intended to help patients access the right care at the right time.

At the same time, WWLHIN recognizes the importance of decreasing demand on the health care system to enhance sustainability. We recognize this can best be achieved by improving the overall health of our population by addressing the determinants of health. In this fiscal year, through review of the current demand and considering the circumstances which predict this demand (especially by vulnerable populations), we will focus more of our efforts toward improving the health of the population and enhancing the sustainability of the health system so it is "there for our children and grandchildren." These efforts will be seen across all priorities. We will also undertake specific efforts that will require broader involvement from our community partners to address the needs of vulnerable populations and fundamentally begin to impact the determinants of health.

French Language Service Plan:

The WWLHIN has 11,500 Francophone residents[1] according to the latest data available through the Health Analytics Branch, Ministry of Health and Long-Term Care. While there are no cities designated under the French Language Services Act, we are committed to ensuring that the needs of the Francophone community are met and we are aware that a request for the designation of three municipalities in our area is presently being studied. We are continuously working to integrate the work of the French Language Services (FLS) Coordinator into all activities of the LHIN to ensure that our work reflects the needs of the francophone community in the most effective way.

While all of the initiatives outlined in this Annual Business Plan apply to all residents, including Francophone residents, we will continue to implement and initiate new activities that will improve services for Francophone residents. Our Action Plan for 2011-2012 includes:

- Work in partnership with the Waterloo Wellington Hamilton Niagara (WWHN) French Language Planning Entity to develop a working framework in order to maximize resources and meet the needs of the francophone community
- Participate in the Ministry/LHIN FLS Working Group to ensure a coordinated approach to FLS while respecting environmental differences in the WWLHIN geographic area
- Participate in inter-ministerial work groups to facilitate access to FLS within the health sector. Some of the on-going projects include: mental health care for children in French schools and integration of health component within the 'Best Start' program in the French community

[1] 2006 Census of Canada Data, analysis by Health Analytics Branch, MOHLTC

- In partnership with the Planning Entity, continue with community engagement activities to better understand the needs of the francophone community
- Monitor and assist with new FLS program initiatives in WWLHIN such as: a) mental health telemedicine program funded by Société santé en français and delivered by a mental health HSP and b) a new multilingual Family Health Team planning to offer services in French to the WWLHIN residents
- Develop an action plan to reflect the recommendations of the WWHN Planning Entity.

The work planned for 2011-2012 will reflect the changes in the environment within our LHIN such as the planning entity and the anticipated designation of some of the cities in the area.

Core Content: IHSP 2010 – 2013 Priorities

IHSP Priority: Improving Patient Safety and Improving Quality of Care

IHSP Priority Description:

The WWLHIN, through extensive community engagement and consultation, identified 'Improving Patient Safety and Quality of Care' as an overarching priority which formed the core of its strategy articulated in Working Together for a Healthier Future: Integrated Health Service Plan 2010 - 2013, the three-year strategic plan for the Waterloo Wellington health system.

This priority was echoed by the Ontario Health Quality Council (now Health Quality Ontario) who found that Ontarians share a common vision of a high-performing health system and who want a publicly funded health system that is accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated and focused on population health.[2]

Current Status:

Enhancing quality and improving patient safety is a key priority for the Waterloo Wellington LHIN and the overarching lens through which progress towards transforming the local health system is evaluated. While our local health service providers are already providing and are accountable for safe, high quality care, there is more that can be done to improve access to care, protect patient safety and improve the patient experience.

The Excellent Care for All Act, 2010 (ECFAA) received royal assent on June 8, 2010, and is intended to improve the quality and accountability of the health system by making health service providers more accountable for improving patient care and the patient experience. As the province's local health system manager, the WWLHIN provides a powerful and strategic vehicle to advance the implementation of the ECFAA across Waterloo Wellington.

In its role as local system manager, the WWLHIN plays a unique role in ensuring overall system level quality. While individual health service providers are responsible and accountable for the quality of the services they directly provide, their actions may also indirectly affect other parts of the health system and thereby create an unsatisfactory experience or outcomes for patients.

In Waterloo Wellington, some of these unplanned and undesirable system dynamics are at play creating longer than necessary Emergency Department (ED) wait times and longer wait-times for patients who are waiting to leave hospital for alternate level of care (ALC). Recognizing that both ED wait times and ALC days are sentinel indicators of system level quality, the WWLHIN has prioritized its planned strategic initiatives to focus on initiatives to address these indicators. As such, while the WWLHIN remains committed to the eight priorities identified in the IHSP, 2010 - 2013, initiatives that support the improvement of ED and ALC quality and patient experience have been given priority for the coming year.

[2] Ontario Health Quality Council 2009.

In addition, the WWLHIN has recognized the importance of not only impacting ED and ALC now but also ensuring such system quality improvement gains are sustained through prevention activities aimed at specific and vulnerable populations and considering the social determinants of health. We need to fix the problems of today while also looking up stream toward prevention efforts.

In summary, the WWLHIN will enhance the quality of the local health care system by implementing initiatives related to the eight priority areas identified in the IHSP 2010 - 2013. These initiatives will include a balance of immediate, mid and longer-term impact, including prevention initiatives, with specific consideration of efforts aimed at vulnerable populations, improving access to ED and decreasing ALC days.

Goals and Action Plans

Goals:

- Reduce non-urgent ED visits by 10% (baseline 2009 - 2010 vs. 2012 - 2013)
- Improve utilization of ED resources
- Improve acute care bed utilization
- Improve services for specific and vulnerable populations.

Consistency with government priorities:

The continuous effort of improving patient safety and enhancing quality of care is consistent with Ontario's goal of attaining the safest and highest quality health system in Canada and with ECFAA. The WWLHIN's approach of focusing on ED wait times and ALC days, as indicators of system level quality, supports the provincial priorities of improving Emergency Department services and reducing ALC days while improving services for patients, including those requiring mental health and addictions services.

Action Plans/Interventions:

The following tables summarize the planned initiatives in 2011 - 2012 for all WWLHIN priority areas in the IHSP 2010 - 2013 and are organized to demonstrate their linkages to Quality Improvement & Patient Safety as the overarching priority and their intended impact on Non-Urgent ED Visits, ED Wait Times, and ALC Days. Special attention is given to specific and vulnerable populations identified through the IHSP 2010 - 2013. Each initiative in its implementation also considers the social determinants of health and value for money in designing and implementing change initiatives. More detail on these initiatives and how they are to be implemented over the coming three years is provided in subsequent sections focusing on each priority area within the IHSP.

Goal: Reduce Non-urgent ED Visits by 10% & Improve Utilization of ED Resources

Quality Healthcare System						
		Implement Excellent Care for All and related initiatives to improve health system quality				
Indicators of System Quality	Emergency Departments: How many access ED (urgent, non-urgent)? How long are they waiting? How many are admitted?					
Objectives	Reduce non-urgent ED visits by 10% (baseline FY 2009/10 vs. FY 2012/13)				Impact Timeline	Appropriate Utilization of ED resources (meet all P4R targets at all P4R hospitals)	
	Primary Care	Chronic Disease Prevention and Management	Addictions and Mental Health	Stroke		In Hospital	Addictions and Mental Health
	Implement new and optimize existing primary care solutions including services for vulnerable populations		Open 32 additional addictions supportive housing beds		Short-Term - now through summer 2011	Develop & implement initiatives to ensure P4R delivers expected system improvements	Increase supports for Long Term A&MH conditions - outpatient programming
	Increase awareness among residents regarding appropriate use of ED and alternatives		*Develop health services component of supportive housing program for mental health clients (support side to addictions supportive housing)*			*Implement Critical Care Surge Capacity recommendations*	
			Strategies to better support the needs of frequent users of ED			Reassess and optimize ambulance offload nurses program	
			Improve transition and navigation from crisis services to more stabilized services				
			Improve links and supports to address crisis mental health needs				
	Startup of NP Clinic and new FHT to meet local needs		Implement Suicide Prevention Strategy	*Implement recommendations of the Improving Access to Quality Stroke Care in Waterloo Wellington Review*	Medium-Term - by March 2012	*Develop and implement a broader communication strategy to inform the public about ED performance*	*Expand coordinated intake and common assessment through community support coordination team - OCAN and related process improvements*
	Expand tele-health and tele-home care		*Implement effective discharge processes from ED & follow-up for all AMH services*			*LHIN-wide decision support capability improvements*	Implement Cambridge Memorial Hospital mental health program
			Implement provincial "no wrong door" approach				
	Implement the Rural and Northern Health Care Framework	*Implement CDPM Framework*	Increase capacity for evidence based health promotion and prevention initiatives		Long-Term - beyond March 2012		
			Increase primary care capacity to address addictions and mental health issues		Unknown	ATC – Access to Care – improve data accuracy, availability and timeliness	
Initiatives Supported by: eHealth, Communications, Community Engagement, Finance, & Performance Monitoring							

Goal: Improve Acute Care Bed Utilization & Improve Services for Specific and Vulnerable Populations

Quality Healthcare System								
			Implement Excellent Care for All and related initiatives to improve health system quality					
Indicators of System Quality	Alternate Level of Care: How many patients require what alternate levels of care? How long are they waiting?				Impact Timeline	Specific and/or Vulnerable Populations		
Objective	Improved acute care bed utilization (decrease % acute bed ALC days to 9.46%; Improved access to community services to enhance hospital discharge opportunities					Decrease MRI wait times (to 28 days by end of 2012/13)	Reduce substance use among youth to the provincial average in all categories (by end of 2012/13)	Improve provision of chronic disease management and self care
	In hospital	In Community	Chronic Disease Prevention and Management	Addictions and Mental Health		MRI	Addictions & Mental Health	Chronic Disease Prevention & Management
	Implement and optimize Home First philosophy across the WWLHIN	Open the planned 192 additional LTC beds			Short-Term - now through summer 2011	Complete implementation of prioritization guidelines and tools		
	Implement initiatives aimed at decreasing ALC designation within 2 days of admission	*Clarify and implement the expanded role of the CCAC*						
		Develop, implement, and optimize the 2011/12 Transitional Care program						
		Optimize coordinated access to community support services for seniors						
	Expand ED PIP to other areas beyond ED	*Implement initiatives related to Behavioural Support Services in conjunction with provincial initiative*		*Enhance A&MH services for Seniors*	Medium-Term - by March 2012	Implement a central intake process for MRI		Implement Diabetes Registry
	Seniors Friendly Hospital assessment and related system improvements	Finalize and implement the Integrated Hospice Palliative Care Program						
		ABI program development and implementation						
		Residents First quality improvement initiative						
		Adult Day Program Review and Implementation of related System Improvements						
		Coordinated intake for Complex Continuing Care and Rehab Services						
		Long term care home redevelopment			Long-Term - beyond March 2012		Implement a coordinated approach for A&MH promotion and education in schools	
		Implement resource matching tool to facilitate referrals					Provide improved access to AMH services for students	
	CCC/Rehab provincial initiative re: roles and best practices		*Expand peritoneal dialysis to other LTC homes*		Unknown		Implement Drug Strategy across WW	Develop comprehensive renal plan for WWLHIN
	Rehab Review							
Initiatives Supported by: eHealth, Communications, Community Engagement, Finance, & Performance Monitoring								

Measures of Success:

- Non-urgent ED visits will be reduced by 10% (baseline FY 2009 - 2010 compared to yr-end FY 2012 - 2013)
- All Pay-4-Results Targets will be met at all participating hospitals
- % acute bed ALC days will be reduced to 9.5%
- MRI wait-times will be reduced to 28 days by year-end 2012 - 2013
- Substance use amongst youth will be reduced to the provincial average in all categories by year-end 2012 - 2013.

Risks/Barriers to Successful Implementation:

- timeliness of required data
- commitment and capacity of Health Service Providers (HSPs) to contribute to system level initiatives
- human resources constraints across the system
- volume and intensity of change initiatives over a short period of time.

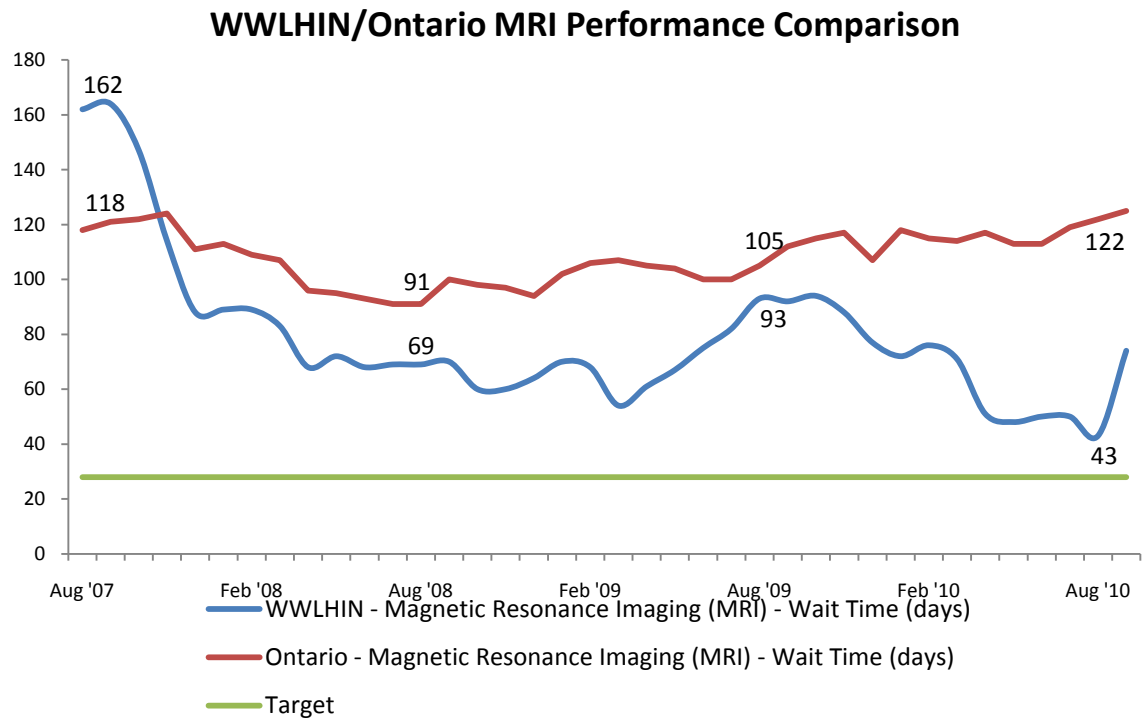
IHSP Priority: Improving Wait Times for Magnetic Resonance Imaging (MRI)

IHSP Priority Description:

As part of the WWLHIN's commitment to improving patient safety and enhancing quality of care, improving wait times for Magnetic Resonance Imaging (MRI) exams was identified as a priority.

The wait time for non-urgent MRI exams has significantly improved over the past several years. Waterloo Wellington had one of the longest wait times in the province when this data was first collected and reported to the public. Through the collective efforts of the WWLHIN and its system partners, wait times for an MRI have dropped 73% since wait times were first reported. Recent temporary equipment shutdowns for maintenance and repair have generated some backlog, but even with these setbacks MRI wait times are still 54% shorter than first measured.

Despite this progress, there is still room for improvement as wait times remain above the provincial target of 28 days.



Current Status:

Waterloo Wellington provides access to Diagnostic MRI scans through three MRI machines; two located in hospitals and one in a privately operated community based clinic. In 2009 - 2010 more than 24,000 MRI exams were provided to residents of the WWLHIN, representing a rate of approximately 33 scans per 1,000 population.

Much progress has been made on improving access to Diagnostic MRI scans within the WWLHIN. System partners have worked cooperatively through the MRI/CT Working Group to improve utilization of the existing capacity. The MRI/CT Working Group has been tasked with identifying service delivery models, processes and best practice clinical guidelines and solutions that will improve capacity, quality and efficiency for MRI/CT services. Significant progress has also been made in the past year on improving prioritization standards and scheduling.

The WWLHIN has also added additional MRI capacity. Hours of service have been expanded to 16 hours/day, 7 days a week for the two hospital based MRIs and in 2010 -2011 an additional 17.7% incremental increase in funding was made available to fund additional cases on these machines. In addition, the number of cases funded in the community based diagnostic clinic was increased by 50% in 2010 - 2011.

The cumulative effect of all of these efforts is that the wait for a non-urgent MRI scan for WWLHIN residents has been significantly reduced since the Wait Times Strategy was first introduced in 2007 - 2008. As of September 2010, 90% of MRI scans were completed within 74 days[3].

In January 2011, the Ministry of Health and Long-Term Care announced funding for the operation of an additional MRI machine at Cambridge Memorial Hospital. The new MRI machine is expected to provide patients with 3,120 scans every year and once up and running will operate for 40 hours a week, which will help further reduce MRI wait times in Waterloo Wellington.

Goals and Action Plans

Goals:

- Reduce MRI wait times to 28 days

Consistency with Government Priorities:

The Ontario government has put a plan in place to increase access and reduce wait times for major health services, including MRI and CT exams. Progress in Waterloo Wellington is making a significant contribution to the achievement of these goals.

[3] MRI Wait times, accessed through iPort Access, September 2010

Action Plans/Interventions:

Goal: Reduce MRI wait times to 28 days

System Improvement Initiative	2011-2012	2012-2013	2013-14
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
Implement prioritization guidelines and tools	25		
Implement additional MRI capacity	50	50	
Implement a central intake process for MRI	50	25	25
Expand central intake process to other diagnostic exams		50	50

Measures of Success:

- Wait time for MRI scans will be reduced to 28 days

Risks/Barriers to Successful Implementation:

- Unscheduled equipment down time and even regularly scheduled equipment maintenance can cause significant service disruptions in a system that is operating so close to its maximum capacity
- Finding an appropriate balance between the hours of operation needed to reach our goal of 28 day wait time and health human resources concerns
- Ensuring that all machines are operating as efficiently as possible and reducing individual scan time
- Opening of new MRI machine contingent on successful fundraising of hospital.

IHSP Priority: Improving Access to Emergency Department (ED) Care

Description:

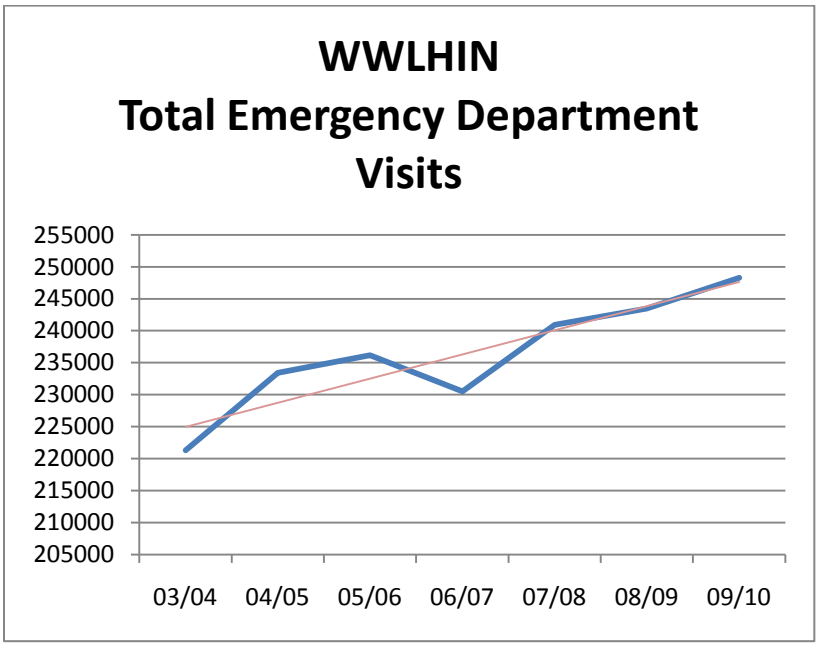
As part of the WWLHIN's commitment to improving patient safety and enhancing quality of care, improving access to Emergency Department (ED) Care has been identified as a priority and a sentinel indicator of overall system quality.

Within the WWLHIN 9 out of 10 patients who go to an ED for an urgent medical issue spend 7.3 hours or less in the ED from the time they register, or initially see a triage nurse, until the time they leave the hospital. For those who require admission to an inpatient bed, 9 out of 10 will reach that hospital bed in less than 26.3 hours. For those who present in the ED with minor uncomplicated issues, 9 out of 10 patients will be treated and leave the hospital in less than 5 hours (Q2 2010 - 2011).

Overall people feel they are waiting too long in Emergency Departments.

Current Status:

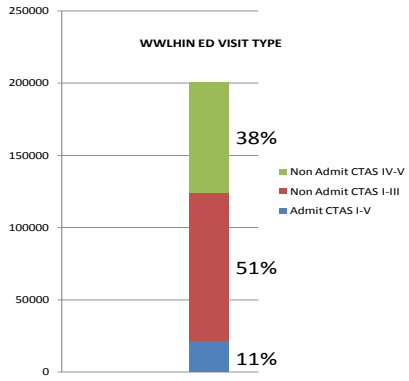
Six hospital corporations within the WWLHIN boundaries operate Emergency Departments at seven sites. Together, these hospitals provided nearly 250,000 ED visits in 2009 - 2010. Growth in ED volumes has been, for the most part, slow and steady with year-over-year growth rates of 1-2%. [4]



[4] Web Enabled Reporting System (WERS)

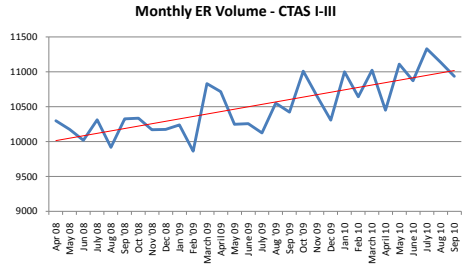
While the majority of patients (62%) presenting in WWLHIN-area EDs require this level of care, there are also a large number of non-urgent patients (38% of all ED visits, representing over 76,000 visits) who could be seen in other settings. Reducing the number of non-urgent cases that present in the ED will enable emergency clinicians to focus on patients with critical needs.

ED Volumes by Type of Visit



A focus on urgent patients is essential as this segment (CTAS I-III) is growing more than twice as fast as the overall Emergency Department volumes. In simple terms, more and sicker patients are arriving in our Emergency Departments.

CTAS I-III
Growing Faster than Other Segments



TOTAL CTAS I-III (Admitted + Non-admitted)

Yr/Yr (2009/10 over 2008/9): 4% growth (twice the overall rate of growth in ED)

Q2/Q2 (Q2 2010/11 to Q2 2009/10): 7% growth

Five WWLHIN hospitals received Process Improvement Program (PIP) Wave 1 funding in 2009 - 2010. The program was designed to improve patient flow and patient satisfaction through evaluating the patient experience from entry to the ED through to discharge from an inpatient unit. All hospitals saw measurable improvements and St. Mary's General Hospital (SMGH) secured bonus funding for strong performance (43% improvement from April 2008 in wait times for admitted patients). All PIP hospitals are committed to sustaining their improvement initiatives, including expanded quality programs and further process improvements.

As of Q2 2010 - 2011 three out of four eligible hospitals in the WWLHIN have earned additional performance funding as part of the province's $100 million investment through the Emergency Department Pay-for-Results (P4R) initiative. This funding has been used thus far for a total of 25 new initiatives, 20 of which began in 2010 - 2011.

New initiatives aimed at increasing ED capacity and performance, both in relation to Pay for Results funding and other community initiatives, include:

- NP coverage in See & Treat
- ER porter
- Improved infection control
- Enhanced DART and Mobile Analytics Repository
- LEAN processes
- Overflow MH beds
- Rapid MED/SURG admission unit
- ED clerical staff
- Flow Coach
- Physician advisor
- Multi-skilled PSW
- Early Physiotherapy intervention
- Medical directive implementation
- Admission/Transfer nurse
- Ward check coverage
- Pharmacist for medical reconciliation
- Transitional Care Program (iLTC, Restorative)
- GEM Nurses, Intensive Geriatric Services Workers (IGSW)
- Home First full implementation
- Long-stay ALC reviews

Hospitals have demonstrated commitment to actions related to reducing ED wait times in their 2010 - 2011 Hospital Service Accountability Agreement (HSAA) extensions. This commitment includes further reductions in Alternate Level of Care Days (ALC), full implementation of Home First, development of long-stay ALC solutions and further population-specific solutions.

Work is also underway to provide services for WWLHIN residents that will help people, particularly seniors, to stay well, remain in their own homes and avoid the need for both ED visits and inpatient hospitalizations. Initiatives include:

- First Link and Access to Care
- Integrated Assisted Living Program
- 50 local longer-term mental health beds
- 288 additional LTC beds being phased in over 3 years
- iLTC beds
- 33 Supportive Housing beds
- 22 Restorative Beds
- Easy Coordinated Access for Community Support Services
- Youth Addictions community aftercare
- Connections for Healthy Aging
- Close to Home
- Intensive Geriatric Services Workers (IGSW)
- Acquired Brain Injury (ABI) Assisted Living Facility
- Peritoneal Dialysis in LTC homes
- Adult Day Program review
- Aging at Home review

Efforts to predict demand for emergency departments is also underway. We are reviewing non-urgent ED visits and identifying prevention activities to better meet needs in the community. For instance, the Nurse Led Outreach Team is working with Long Term Care Homes to put in place services such as IV therapy and mobile x-rays to decrease the need to send residents to emergency rooms. Primary care physicians are working with emergency departments to enhance their support to help their patients avoid use of emergency departments. As well, the WWCCAC is enhancing their case management with respect to anticipating the changing needs of their clients to avoid the need for emergency services.

Goals and Action Plans

Goals:

- Non-urgent ED visits (CTAS 4,5) will be reduced by 10 percentage points
- Ensure appropriate utilization of ED resources.

Consistency with Government Priorities:

Reducing Emergency Department wait times is a key component of the provincial ED/ALC strategy. By focusing efforts on two key areas (reducing non-urgent ED visits and appropriate utilization of ED resources) overall ED wait times, quality of care and the patient experience are expected to improve.

Action Plans/ Interventions:
Initiatives described below are also identified within other priority action plans because they relate not only to the IHSP priority area but are also intended to impact this priority.

Goal: Non-urgent ED visits will be reduced by 10 percentage points*

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
Primary Care			
Implement new and optimize existing primary care solutions including services for vulnerable populations	25	25	10
Increase awareness among residents regarding appropriate use of ED and alternatives	50	25	25
Start-up of Nurse Practitioner (NP) Clinic and new Family Health Team (FHT) to meet local needs	100		
Expand tele-health and tele-homecare	25	ongoing	

Goal: Non-urgent ED visits will be reduced by 10 percentage points* continued…

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
Chronic Disease Prevention and Management (CDPM)			
Implement CDPM Framework	75	25	
Addictions and Mental Health			
Open 32 additional addictions supportive housing beds	100		
Develop health services component of supportive housing program for mental health clients (support component to addictions supportive housing)	50	25	
Strategies to better support the needs of frequent users of ED	50	25	25
Improve transition and navigation from crisis services to more stabilized services	25	25	25
Improve links and supports to address crisis mental health needs	50	25	25
Implement Suicide Prevention Strategy	25	25	25
Implement effective discharge processes from ED & follow-up for all AMH services	25	25	25
Implement provincial “No Wrong Door” approach	50	25	
Increase capacity for evidence based health promotion and prevention initiatives	25	25	25
Increase primary capacity to address addictions and mental health issues	ongoing		
Stroke			
Implement the recommendations of the Stroke Services Review	25	25	25

Goal: Ensure appropriate utilization of ED resources

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
In Hospital			
Develop and implement mechanisms to ensure "Pay for Results" delivers expected system improvements	ongoing →		
Implement Critical Care Surge Capacity recommendations	25	0	
Reassess and optimize ambulance offload nurses program	25	0	
Develop and implement a broader communication strategy to inform the public about ED performance	75	25	
LHIN-wide decision support capability improvements	50	50	
ATC – Access to Care – improve data accuracy availability and timeliness	50	50	
Addictions and Mental Health (A&MH)			
Increase supports for Long Term A&MH conditions – outpatient programming	25	25	25
Expand coordinated intake and common assessment through community support coordination team	100		
Implement Cambridge Memorial Hospital mental health program	100		

Measures of Success:

- Increased proportion of non-admitted high acuity patients treated within the length of stay target of less than 8 hours
- Increased proportion of non-admitted low acuity patients treated within the length of stay target of less than 4 hours
- Continue to reduce the proportion of non-urgent (CTAS IV-V) ED visits from our starting point of 45% towards our goal of 35% of ED visits.

Risks/Barriers to Successful Implementation:

- Gains made during ED PIP must be maintained and successfully translated to other areas of the hospital
- Uneven distribution of primary care services across WWLHIN translates into fewer after hours care options in some geographies
- Health Human Resources constraints continue to be a limiting factor in implementing certain initiatives
- Rates of chronic diseases in WWLHIN are on the rise, which will continue to put pressure on Emergency Department resources.

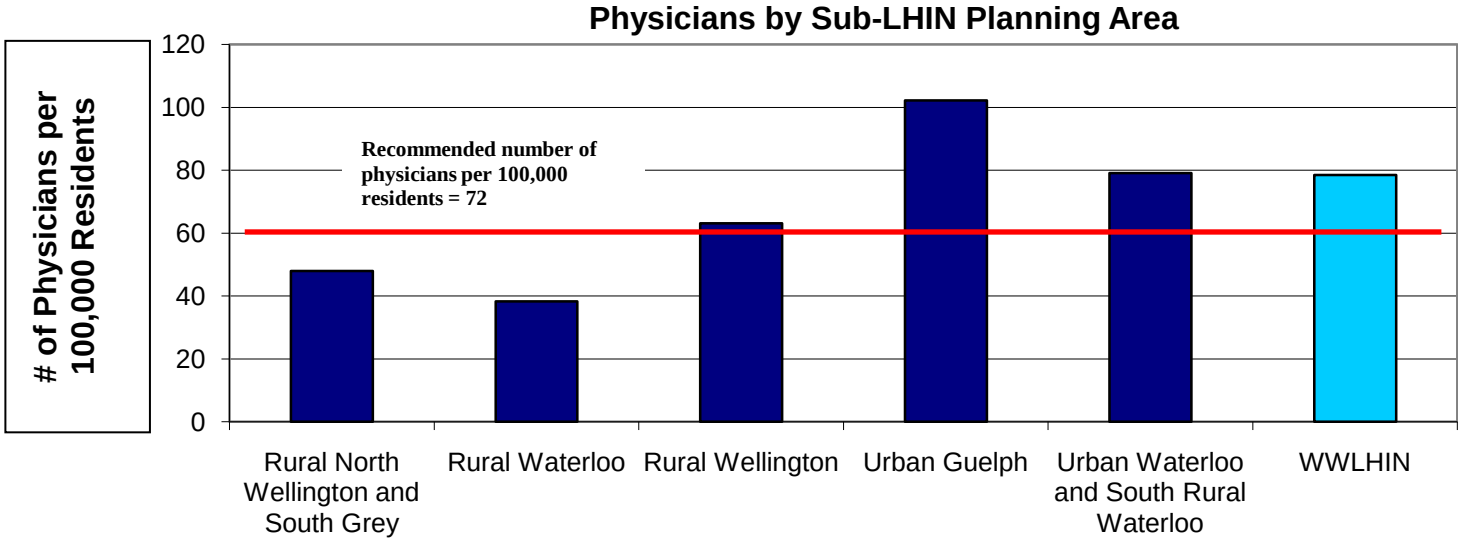
IHSP Priority: Improving Access to Primary Care

IHSP Priority Description:

Primary health care services play an important role in prevention of disease and treatment of illness as well as chronic disease management and as such are fundamental to a health system that delivers high quality care. The WWLHIN is committed to ensuring that these services are easily accessible for all residents in Waterloo Wellington.

Current Status:

According to several sources, approximately 95% of residents in Waterloo Wellington have a primary care physician or place where they go for regular primary care[5] which is slightly higher than the provincial average. From a supply perspective, the WWLHIN has approximately 555 physicians (2007) who serve a population of approximately 690,000. This is better than the recommended target of 72 primary care physicians per 100,000 of population.



While physician supply appears adequate, distribution across the WWLHIN is not uniform and as such there are a number of service gaps:

- A rate of approximately 5% unattached residents represents more than 34,000 people who remain without a regular primary care provider
- The three rural areas of the WWLHIN, (rural Waterloo Region, rural Wellington, and rural North Wellington and South Grey)[6] have fewer primary care physicians
- Specific vulnerable populations have challenges accessing primary care; as an example, only 68-80% of recent immigrants reported having a regular doctor, compared to 95% of the population at large[7]

[5] MOHLTC Primary Care Access Survey 2008, WWLHIN survey 2009, Statistics Canada, Canadian Community Health Survey.
[6] Ontario Physician Human Resources Data Centre – Active Physicians in Ontario by Census Subdivision, 2008
[7] Primary Care Access Survey Waves 5-12 January 2007-December 2008

- Access for people who are homeless or at risk of homelessness is challenging
- Members of the Lesbian Gay Bisexual Transsexual/Transgender Queer (LGBTQ) community also reported having to go outside of their local area to find a provider who has knowledge of their specific health needs and issues[8]
- 63% of WW residents said it was very to somewhat difficult to access after-hours care[9]
- 38% of total emergency department visits were non-urgent (CTAS 4,5) – these people could have been managed in another setting.[10]

There has however been recent progress on improving access to primary care:

- Health Care Connect, a provincial program that helps people who do not have a primary care provider to find one, has had 4389 Waterloo Wellington residents registered with the program
- Introduction of the Care Connectors through the Waterloo Wellington Community Care Access Centre (WWCCAC) has helped match 491 registrants with a primary care provider
- An additional Family Health Team in Guelph (Mango Tree FHT), which will also provide French Language Services, and a new Nurse Practitioner Led Clinic at Conestoga College in Kitchener, were approved in 2010
- A rural community, previously without a physician, has successfully recruited a new physician who opened his practice in November 2010.

In addition, the WWLHIN along with its partners has been engaged in a series of clinical transformation projects that piloted electronically enabled care models and allowed information sharing between patients and their care teams, aimed at improving health outcomes and delivering high quality, cost-effective care.

The ***HEALTHeCONNECTIONS*** project was a two-year project to demonstrate the effectiveness of an eHealth-enhanced chronic disease management model tailored for patients living with diabetes. Nearly 1,000 patients and hundreds of health care providers participated.

The project was about the patients – improving their level of care by getting them actively involved in the management of their disease, giving them more control and understanding of their condition and immediate access to their medical record and healthcare team – all through the convenience of their personal computer.

The HEALTHeCONNECTIONS project has been a success. Both primary and secondary indicators of health status improved, patients felt they were better able to manage their diabetes with the support of the portal, and physicians reported that levels of care improved.

[8] WWLHIN Lesbian Gay Bisexual Transsexual/Transgender Queer (LGBTQ) Online Survey, July 2009

[9] Attitudes and Behaviours Toward the Health Care System in the Region Served by the WWLHIN, Final Report April 2009

[10] Emergency Department Visits, 2009/10

Goals and Action Plans

Goals:

- Ensure all residents of Waterloo Wellington have access to primary care
- Improve utilization of primary care by vulnerable populations
- Increase the number of residents who access after-hours care.

Consistency with Government Priorities:

Improving access to primary care services will help improve emergency department wait times by decreasing demand for emergency department services. When residents of Waterloo Wellington have a primary care provider who offers after-hours care and those residents know how to access this care, we will have fewer people going to the emergency department. This means that ED resources will be freed up for more complex patients, which will lead to an overall reduction in ED wait times. Furthermore, patients will receive the best care in the most appropriate setting.

Action Plans/Interventions:

Goal: Ensure all residents of Waterloo Wellington have access to primary care

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
Continue to implement Rural Health Care Review recommendations	50	ongoing	
Expand tele-health and tele-home care	25	ongoing	
Startup of NP Clinic and new FHT to meet local needs	100		
Increase awareness among residents regarding appropriate use of ED and alternatives	50	25	25

Goal: Improve utilization of primary care by vulnerable populations
Goal: Increase number of residents who access after-hours care

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
Implement new and optimize existing primary care solutions including services for vulnerable populations	25	25	10

Measures of Success:

- Increased percentage of WWLHIN residents who have a primary care provider – specifically among rural residents and various vulnerable populations
- Decreased number of non-urgent ED visits for people who have a primary care provider.

Risks/Barriers to Successful Implementation:

- WWLHIN does not have service accountability agreements with most primary care providers which makes it difficult to influence behaviour and measure outcomes
- Physician resources are not distributed uniformly across the WWLHIN, nor is it within the WWLHIN's mandate to manage that distribution
- Recruiting primary care practitioners to areas where there is most need (particularly rural areas) continues to be a challenge and physicians' choice to work part-time or retire early can amplify recruitment needs
- Although legislation is in place to allow greater scope of practice for certain health care professionals, clinical practice is much slower to change
- Aggregate statistics of 'attached' and 'unattached' patients fail to illuminate geographic differences in access to care. Access to valid sub-LHIN data is currently unavailable.

IHSP Priority: Improving Access to, and Coordination of, Addictions and Mental Health Services

IHSP Priority Description:

During the past several years, addictions and mental health issues have been increasing among residents in the WWLHIN. Between 2005 and 2009, both mood and anxiety disorders have increased in prevalence.[11] Substance use among Waterloo Wellington students exceeds that of the provincial average in all categories, as does substance use among Waterloo Wellington adults.[12] The WWLHIN also has a higher rate of intentional self harm than that of the province.[13]

Current Status:

A range of addictions and mental health services, including inpatient, outpatient and community-based services, are available to residents of Waterloo Wellington.

In-patient services are largely focused at two hospitals within the WWLHIN, with a third privately owned and operated hospital providing significant capacity to both publicly funded and private clients.

In 2009 - 2010, the Waterloo Wellington LHIN had 95 publicly funded mental health beds, and an additional 252 privately owned and operated beds that served privately insured and private pay clients. In 2009 - 2010, there were approximately 4570 mental health inpatient separations. Two WWLHIN hospitals (Cambridge Memorial Hospital and Grand River Hospital) also provide out-patient care which includes: child/family/seniors mental health services, community outreach, crisis team, medication follow-up and withdrawal management.

Over the past year, progress has been made on a number of fronts. Additional funding has been provided for psychiatric services through increased sessional funding, which will result in better coordination of mental health and addictions services, enhance access to services for vulnerable populations, and will assist with the recruitment and retention of psychiatric resources to Waterloo Wellington.

In-patient services are being expanded and new programming to support these expansions has been developed. This includes the development of an integrated program for the severe and persistently mentally ill which will allow patients to receive treatment closer to home. In 2010 - 2011, the addition of 77 mental health beds are planned for Waterloo Wellington.

Much progress has been made by Health Service Providers who have been working together to integrate services and make them easier to access and navigate. Highlights of this progress include:

- A voluntary integration between the Self Help Alliance and Canadian Mental Health Association, Grand River Branch, in the fall of 2010,which reduced the number of WWLHIN funded community-based service providers from 22 to 21
- WW Addiction and Mental Health Network developed a detailed map of services across Waterloo Wellington and is developing strategies to optimize services and reduce gaps

[11] Canadian Community Health Survey 2005, 2007, 2008, 2009
[12] Ontario Student Drug Use and Health Survey, 2007
[13] OHQC Quality Monitor Report 2010

- A pilot program was completed and progress continues on the implementation of specialized mental health supports in emergency departments to improve discharge planning for patients with addictions and mental health issues
- A common crisis planning process was developed, including a common crisis pathway and orientation DVD, shared assessment tools and WWLHIN-wide sharing of crisis plans which will help to improve coordination of crisis services
- Joined with our regional partners to support the implementation of a drug strategy for the City of Guelph and Wellington County which is ongoing; this will result in strategies to respond to the issues, gaps and needs related to drug and alcohol misuse in this area
- A program for addictions supportive housing and outreach in Waterloo Wellington was developed which will increase housing stability for people with problematic substance use.

Despite the considerable progress that has been made there is still more to do. The local health system is having difficulty fully meeting the needs of people who suffer from addictions and mental health issues. In Waterloo Wellington, patients with mental health disorders account for the second highest number of long-stay ALC patients among patients over the age of 55. The rate of inpatient hospitalization for depression in Waterloo Wellington is twice as high as the province and the ED visit rate in WW is also greater than that of the province.

By targeting preventative programs for this group of patients and focusing on better follow-up care, some of the pressure experienced by the health system can be reduced and patients can be assured they will get the best possible care in the most appropriate setting. As well, we know a number of factors determine overall health including mental health. These determinants of health as they are commonly known include things like social supports, housing and education and all contribute to the mental health and wellbeing of individuals. We will work with our community partners including municipalities, school boards and public health with a particular focus on vulnerable populations and youth to develop earlier interventions and enhanced primary prevention.

Goals and Action Plans

Goals:

- Reduce substance use among youth to the provincial average in all categories
- Reduce mental health issues among youth
- Decrease readmissions and inappropriate ED use to provincial averages
- Improve access to services.

Consistency with Government Priorities:

Improving Mental Health and Addictions services is a priority for the Government of Ontario. In addition, improving these services will also help to improve services in Emergency Departments and reduce ALC days, both of which are also areas for priority focus.

Improvement Initiatives:

Goal: Reduce substance abuse and mental health issues among youth

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
Implement Drug Strategy across WW	25	25	25
Implement Suicide Prevention Strategy	25	25	25
Implement a coordinated approach for A&MH promotion and education in schools	50	25	25
Provide improved access to AMH services for students	25	50	25

Goal: Decrease readmissions and inappropriate ED use to the provincial averages

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
Expand coordinated intake and common assessment through community support coordination team	100		
Implement effective discharge processes and follow up for all addictions and mental health services	25	25	25
Increase supports for long-term addictions and mental health conditions	25	25	25
Implement provincial program called “no wrong door approach”	50	25	
Improve transition from crisis services to more stabilized services	25	25	25
Enhance mental health services for seniors	25	50	
Increase capacity for evidence based health promotion and prevention initiatives	25	25	25
Strategies to better support the needs of frequent users to the ED	50	25	25

Goal: Improve access to services

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
Develop health services component of supportive housing program for mental health clients	50	25	
Open 32 additional addictions supportive housing beds	100		
Increase primary care capacity to address addictions and mental health issues	ongoing		
Implement Cambridge Memorial Hospital mental health program	100		

Measures of Success:

- Decreased rate of repeat unplanned ED visits within 30 days for mental health conditions to 11.6%[14]
- Decreased rate of repeat unplanned ED visits within 30 days for substance use conditions to 16.8%[15]
- Decreased percentage of students reporting substance abuse to the provincial average in all categories
- Decreased percentage of mental health issues among youth
- 30-day readmission rates for addictions and mental health conditions will continue to be below the provincial average
- Decreased ED visit rate for addictions and mental health issues that could be managed elsewhere
- Increased percentage of WWLHIN residents accessing community addictions and mental health services.

Risks/Barriers to Successful Implementation:

- The WWLHIN does not have service accountability agreements with most primary care and some mental health providers, particularly for youth, who play an integral role in ensuring we achieve our objectives. As a result, it is more difficult to influence behaviour change and measure outcomes
- Tier 3 divestment and subsequent reinvestment in community programs has not yet occurred
- The state of the economy will likely lead to an increased demand for addictions and mental health services[16]
- Need to identify, document and address underlying causes and other diagnoses for ED visits and hospital discharges

[14] MOHLTC Quarterly Stocktake Report August 2010
[15] MOHLTC Quarterly Stocktake Report August 2010
[16] Gallo et. al, 2006 & Eliason & Storrie, 2009 in Appendix 4 WWLHIN IHSP 2010-2013

- Addictions and mental health services are funded from many sources, including other ministries, insurance companies and private providers, which create challenges in managing distribution and outcomes for these services.
- Need to address issues facing community mental health including wait times for community services, lack of community-based psychiatry and consequent inappropriate ED use.

IHSP Priority: Improving Chronic Disease Prevention and Management

IHSP Priority Description:

The World Health Organization (WHO) identified chronic disease as a fast growing and serious global issue whose impact on the health of communities and health care economics requires urgent and effective response and action.

The Waterloo Wellington Local Health Integration Network's Integrated Health Service Plan, 2010 - 2013 also identified "improving chronic disease prevention and management" as one of the eight priorities. Aligning with the priorities and strategies at all levels of the health care system will leverage the resources necessary to establish and implement prevention action plans and effective chronic disease reduction.

Current Status:

Of the approximately 740,000 residents in the WWLHIN, 70% reported having at least one chronic condition in 2007[17]. While there is room for improvement, for most people, managing one chronic disease is very feasible and there is usually little impact on the health care system. On the other hand, seniors with three or more reported chronic conditions used 40% of health care provided to seniors, even though they account for only 24% of the senior population. (CIHI 2011)[18]

Further, having more than one chronic disease interferes disproportionately with quality of life. For example, the Canadian Institute for Health Information (2011) found that, among seniors with one chronic disease, 88% reported that their health status was "good," "very good" or "excellent, compared to 92% of those with no chronic diseases. However, seniors with three or more reported chronic conditions, 49% rated their health status as worse than "good".

Having three of more conditions means that seniors were taking twice as many medications as those with one chronic condition, and the problems with keeping the medications straight without complications is more difficult the more there are. (CIHI 2011)

The incidence and impact of chronic conditions is not equally spread across the population. As an example, the rates of diabetes and heart disease among the poorest 20% of the population are more than double the rates of the richest 20% of the population (Wilson Lightman and Mitchell 2009). Women in the lowest income quintile are 1.7 times more likely to have diabetes after adjusting for age, body mass index, drinking, smoking, and physical inactivity (Ross et al 2010), and this income effect is most noticeable in the age group 35-64.

[17] 2007 Canadian Community Health Survey, Statistic Canada

[18] Canadian Institute for Health Information, *Seniors and the Health Care System: What is the Impact of Multiple Chronic Conditions?* (Ottawa, ON: CIHI 2011).

Diabetes Prevalence Rates by Income Quartile

Exhibit 1.3 Prevalence of DM per 100 Ontarians by Socioeconomic Status (Median Neighbourhood Income), 1999

There is a marked socioeconomic gradient in the prevalence of DM with higher rates in the lower income quintiles. This effect is most evident in the 35–64 year age groups.

Income Quintile	Overall Prevalence	Women by Age Group					Men by Age Group				
		20–34	35–49	50–64	65–74	75+	20–34	35–49	50–64	65–74	75+
Q1 (lowest)	7.26	1.17	4.13	11.11	16.82	18.89	0.89	4.72	14.22	20.26	23.13
Q2	7.05	1.07	3.42	9.59	14.51	17.13	0.85	3.88	13.54	18.91	22.14
Q3	6.78	1.03	3.21	9.20	14.54	17.40	0.82	3.81	13.90	19.54	22.93
Q4	5.76	0.93	2.64	8.26	13.85	16.54	0.75	3.32	11.86	19.05	21.82
Q5 (highest)	5.12	0.93	2.38	7.62	13.96	17.02	0.68	2.95	12.02	19.70	22.08

Source: Ontario Diabetes Database (ODD)

Denominators for calculation of these rates were taken from 1996 census data rather than the Statistics Canada postcensal estimates used elsewhere in this chapter. As a result, the magnitude of the rates is slightly inflated relative to the overall rates shown in Exhibit 1.1. However, patterns of DM across the age, sex and SES strata are valid.

Hux, Tang (2003)[19]

Not only are they more likely to have disproportionate share of chronic diseases, those with the lowest incomes have worse outcomes from their conditions than richer citizens. For example, those with the lowest 20% income group are more likely to die from cardiovascular disease than those in the highest income group (James, Wilkins, Detsky, Tugwell, Manuel, 2007)[20] and lower income women are more likely to die of breast cancer than higher income women, even though their cancers are generally detected at the same stage. (Booth et al 2010).[21]

Of concern is a distinct trend within Waterloo Wellington towards unhealthy behaviours commonly known to be associated with the development of chronic disease. Smoking, drinking and obesity are all more prevalent in the WWLHIN than the province, and overweight and obesity are increasing, with 50% of the WWLHIN population already overweight or obese. In addition, both physical activity and fruit and vegetable consumption are on the decline. All these "risk factors" are more highly associated with lower income than higher income. (Wilson, Eyles, Elliott, Keller-Olaman, 2008)

In May 2007, the Ministry of Health & Long-Term Care (MOHLTC) released "*Preventing and Managing Chronic Disease: Ontario Framework*" which is designed to inform planning for chronic disease prevention and management in Ontario. It is intended to help move the system

[19] Hux J.E., Tang T., Patterns of Prevalence and Incidence of Diabetes, in Hux J E, Booth G L, Slaughter P M, Laupacis A (eds). Diabetes in Ontario: An ICES Practice Atlas: Institute for Clinical Evaluative Sciences. 2003: 1.1-1.18.

[20] James, P. D., Wilkins, R., Detsky, A. S., Tugwell, P., & Manuel, D. G. (2007). Avoidable mortality by neighbourhood income in Canada: 25 years after the establishment of universal health insurance. Journal of Epidemiology and Community Health, 61, 287-296

[21] Booth, C. M., Li, G., Zhang-Salomons, J., & Mackillop, W. J. (2010). The impact of socioeconomic status on stage of cancer at diagnosis and survival. Cancer, 116, 4160-4167.

from the current reactive, acute, episodic model of care to a proactive population based interdisciplinary practice model of care.

The Ontario CDPM Framework provides the guidance to integrate and coordinate a system-wide approach to chronic disease management which will help the WWLHIN move towards the vision of a model focused on improved health for the population and better and more appropriate access to health care for those most at risk for chronic diseases. The key elements in the Ontario CDPM Framework will be used within the WWLHIN to assess the services, activities and initiatives underway within the area to support chronic disease, to evaluate the current state, to identify gaps across the system and to identify and create opportunities for integration, coordination and, if possible, expansion of services.

In order to focus strategically on moving forward on system re-design, diabetes and hypertension were identified as early priorities. Eight per cent of adults 45-64 report diabetes (and 17% of seniors, 65 and over), and 23% of those in the 45-64 age bracket report hypertension (47% of seniors). Eleven per cent of seniors suffer from both conditions, and they are the third most common pair of chronic diseases suffered by seniors. (CIHI, 2011)

Prioritizing diabetes and hypertension as the first two to receive focus will help guide future efforts on other chronic diseases. Lessons learned will help create a model that can be applied again. Recognizing that these two diseases have similar risk factors, both at the intermediate stage (eg, obesity) and at the ultimate stage (ie, the underlying factors that are associated with obesity, low physical activity: low income, poor education, food insecurity, employment insecurity, etc.) provides a good focus for future action on chronic disease. Given the complexity of the factors at issue, it must be recognized that change will take time. Noticeable reductions in prevalence and incidence rates will not be seen for several years, but given that the diseases overlap in a significant part of the population will assist in identifying more appropriate health system responses to change care and care patterns sooner.

Local work has already begun in Waterloo Wellington and progress is starting to be seen:

- The community has been engaged to provide input into the development of a comprehensive framework and implementation plan for chronic disease prevention and management (CDPM) of diabetes and hypertension; the framework provided an in-depth understanding of the current system including current achievements and opportunities for improvement

A number of providers are starting to more specifically focus their supports towards the vulnerable and the WWLHIN is increasingly setting higher expectations in this regard.

- The Regional Diabetes Coordination Centre performed an environmental scan and inventory of services which informed the development of the WWLHIN 2011 - 2014 Diabetes Service Plan, which aligns with the WWLHIN CDPM Framework

- Home dialysis has been expanded, in partnership with the Regional Renal Program; 24.6% of patients are now receiving care at home, which is higher than the provincial rate of 22.4%

- 100 more bariatric surgeries have been performed and a follow-up program is helping to reduce complications and co-morbidities, following patients for up to five years post-surgery

- ***HEALTHeCONNECTIONS*** demonstration project was completed and Phase 2 planning and implementation is underway; this project allows patients to securely communicate with their primary care providers and gives them tools to track and monitor their own health status

- Diabetes teams have been expanded, which will allow more residents with diabetes to have timely access to services closer to home

- Improvements have been made to the WWLHIN vascular program, which means that many residents will no longer have to travel outside the area to receive these services.

Goals and Action Plans

Goals:

- Improve the provision of chronic disease management and self care
- Improve access to specialized services for patients with chronic conditions.

Consistency with Government Priorities:

Improving access to, and the provision of, services for residents living with chronic conditions is consistent with the Ministry of Health and Long-Term Care (MOHLTC) priority of supporting the implementation of Ontario's Diabetes Strategy (ODS) with an aim to prevent, manage and treat diabetes care across the province. In addition the MOHLTC launched "*Preventing and Managing Chronic Disease: Ontario Framework" in May 2007*. Many of the initiatives underway, and planned for the next three years, will focus on improving self-management and provision of services for persons with diabetes and hypertension. In addition, the infrastructure, IT and programs that are being developed are intended to address other chronic conditions in the future and are consistent with a variety of e-Health initiatives led by the MOHLTC e.g. Diabetes registry.

Action Plans/ Interventions:

Goal: Improve the provision of chronic disease management and self care

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
Implement CDPM Framework plans	75	25	
Implement Diabetes Registry	35	25	25

Goal: Improve access to specialized services for patients with chronic conditions

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
Expand peritoneal dialysis to additional Long-Term Care homes	25	25	
Develop comprehensive renal plan for WW	100		

Measures of Success:

- Increased percentage of people with diabetes, aged 18 and older, who have had all three diabetes tests, cholesterol, retinal eye exam and the HbA1C test (a measure of blood sugar control) within the recommended guideline
- Increased percentage of dialysis patients who receive their dialysis at home to 35% (Ontario target)
- Increased number of annual bariatric surgeries
- Decreased percentage of ED visits for persons with diabetes and/or hypertension
- Decreased percentage of hospitalizations for persons with diabetes and/or hypertension
- Increased percentage of people who report that their primary care provider is regularly involved in the management of their chronic condition
- Over time, a decrease in chronic disease incidence and prevalence in the population.

Risks/Barriers to Successful Implementation:

- Determinants of health have an impact on health status of the population and are often difficult to effect
- Compliance with testing and lifestyle modifications will remain an issue
- WWLHIN does not hold service accountability agreements with Family Health Teams or other primary care providers and other organizations (e.g. Public Health) who play an integral role in chronic disease prevention and management.

IHSP Priority: Improving outcomes for stroke patients through integrated programs

IHSP Priority Description:

As part of the WWLHIN's commitment to improve patient safety and enhance quality of care, improving outcomes for stroke patients was identified as a priority.

Within the WWLHIN, stroke was the third most common cause of death and the ninth most common chronic disease. The risk of stroke is increased by a number of factors, including age, chronic conditions such as diabetes, and unhealthy lifestyles. It has been estimated that by 2024 the number of strokes in the WWLHIN may increase by as much as 50%.

As part of the Ontario Stroke Network, the WWLHIN has an organized approach to stroke that stretches across the continuum of care. However, a review of stroke care in the WWLHIN identified a number of areas that could be optimized and weaknesses that need to be addressed. The most current available data suggests that, even after adjusting for age and sex, the rate at which WWLHIN stroke patients die in hospital or within 30 days is greater than the provincial average. Compared to Ontario as a whole, a smaller proportion of WWLHIN stroke survivors are sent to in-patient rehabilitation programs and somewhat more are discharged to long-term care or complex continuing care. Moreover, there is evidence suggesting that not all parts of Waterloo-Wellington are benefiting equally from organized stroke care.[22]

Current Status:

In 2007 - 2008, the age and sex-adjusted rate of stroke/TIA (transient ischemic attack) patients arriving in emergency departments in the WWLHIN was 1.3 per 1,000 population, which was similar to the provincial average of 1.4 per 1,000. This translated into 2,418 Emergency Department (ED) visits due to stroke. It is the current practice that patients be transported to the facility best suited to their care, whether or not the hospital is within the WWLHIN boundaries. Grand River Hospital saw the most patients (45%) with smaller numbers going to Guelph General, Cambridge Memorial, St. Mary's General, Groves Memorial and the two North Wellington sites.

Grand River Hospital is the District Stroke Centre and has a dedicated stroke unit with 12 beds. Although the Guelph General Hospital does not have a stroke unit, it does have an interdisciplinary team that follows a stroke protocol and best practice guidelines. In the five remaining hospitals, stroke care is provided in general medicine nursing or general rehab nursing units.

The Regional Stroke Centre is Hamilton Health Sciences. Regional Stroke Centres provide regional leadership to District Stroke Centres and stroke prevention clinics. They ensure integrated and coordinated regional stroke rehabilitation services and work with various stakeholders to develop a consistent approach to stroke care across the region.

[22] Waterloo Wellington Stroke Review, 2010

Studies have shown that stroke patients treated in non-specialized units may have less optimal outcomes than those treated on a dedicated stroke unit with a dedicated team. In this regard there are a number of key issues to be addressed:

- Stroke in-hospital mortality rate for WWLHIN between 2005 - 2006 and 2007 - 2008 was the second highest in the province[23]
- As of 2005 – 2006, readmission rates within three months following stroke were the second highest in the province[24]
- In 2004 - 2005, fewer WWLHIN residents who suffered from a severe stroke were sent to in-patient rehabilitation (26.4%), which was lower than the provincial average at that time (35.1%). The percentage of severe stroke patients sent to in-patient rehabilitation in 2004 - 2005 dramatically decreased from the percentage in 2002 - 2003, which was 51.3%. During the same time period, the number of severe stroke patients being sent to LTC increased from 2.0% to 17.9% which was higher than the provincial average of 11.9% in 2004 - 2005.[25]

In the past year, a review of current stroke care practices was undertaken by the WWLHIN in collaboration with the Central South Regional Stroke Network and the Ontario Stroke Network. The review encompassed acute care, rehabilitation and secondary prevention services for stroke in the WWLHIN. Local Health Service Providers participated as members of the Steering Committee.

As a result of this collaborative work, many positive service improvement initiatives are underway and more are planned.

- Three facilitators have been trained (two professionals and one stroke survivor) to offer "Living with Stroke" education programs to rural communities
- More than 1300 high school students engaged in education sessions on healthy lifestyles and its importance in stroke prevention
- RNAO best practice smoking cessation guidelines have, so far, been implemented at four out of eight WWLHIN hospitals
- A model for clustering acute stroke care across the Hamilton Niagara Haldimand Brant and WWLHINs was developed
- A plan for system-wide Emergency Medical Services (EMS) services was developed, including changes to the expanded window for tPA
- The timeframe to safely administer the drug tPA was expanded from 3.0 hours to 4.5 hours at Grand River Hospital in 2009 - 2010 and at the remaining hospitals during 2010 - 2011
- A standard assessment tool (Alpha-FIM) is now used to assess all stroke patients within 48-72 hours following a stroke and provides valuable information that helps to determine appropriate rehabilitation needs
- A dysphagia screening tool, initially implemented at Grand River Hospital, has since been implemented in all hospitals in the WWLHIN that are delivering acute stroke care. This is a very simple swallowing test that helps to identify stroke patients at risk for aspiration pneumonia
- Standardized best practice guidelines for stroke and TIA including acute stroke orders and care maps have been implemented at all hospitals across the WWLHIN and an ongoing

[23] Health Indicators Report, 2009. Canadian Institute for Health Information
[24] Ontario Stroke Evaluation Report 2006: Technical Report
[25] Registry of the Canadian Stroke Network – Report on the 2004/05 Ontario Stroke Audit

mechanism to update these annually to reflect Canadian best practice recommendations is in place
- Community stakeholders have been actively engaged in the development of standardized best practice guidelines for community based care
- Community re-integration of stroke survivors is supported by linking "survivors with survivors" a project that has been implemented at all hospitals across the WWLHIN.

Goals and Action Plans

Goals:

- Improve prevention and management of stroke by primary care providers
- Reduce readmission rates and mortality rates to the provincial average.

Consistency with Government Priorities:

The WWLHIN's IHSP Priority of improving outcomes for stroke patients through integrated programs aligns with the Ministry of Health and Long Term Care's Framework for Chronic Disease Prevention and Management (CDPM).

The best research evidence to date indicates that the Framework's approach to CDPM will improve the health and functioning of chronically ill Ontarians and reduce the incidence of chronic disease in the province. These outcomes will result from both increased prevention/promotion in clinical practice and in the community, as well as improved delivery of chronic disease care. The improved delivery of care, including to those patients who have experienced a stroke, will not only ensure quality care in the appropriate setting by the appropriate provider at the right time, but will also increase efficiency in the system.

Action Plans/ Interventions:

Goal: Improve primary prevention and management in primary care

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
Implement education sessions for high school students focused on stroke prevention	25	25	25
Implement "Living with Stroke" education program with Mennonite population	25	25	25
Strengthen linkages to promotion and public awareness of signs and symptoms of stroke with CHCs and FHTs – expand to other models of primary care	25	25	25
Implement RNAO best practice smoking cessation guidelines at all WWLHIN hospitals	25	25	

Goal: Reduce readmission rates and mortality rates to the provincial average

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
Develop a model for clustering stroke care (acute and rehab) across HNHB and WW LHINs	50	0	
Implement a plan for system wide EMS services for stroke patients across WWLHIN	25	0	
Expand Alpha-FIM across WWLHIN	25	0	
Expand dysphasia screening tool to acute care facilities across WWLHIN	25	0	
Implement a regional evaluation and monitoring mechanism to track optimization and best practice stroke care across the continuum	25	25	25
Implement clustered stroke units across WWLHIN (acute and rehab)	50	50	
Implement standard assessment tools for acute and rehab care across WWLHIN	25	50	
Implement stroke navigation tool across WWLHIN	50	50	
Implement recommendations from WWLHIN Stroke Services Review	25	25	25

Measures of Success:

- Increased change in FIM scores (rehabilitation assessment tool) during inpatient rehabilitation
- Decreased 30-day readmission of patients with stroke to acute care
- Decreased 30-day stroke in-hospital mortality rate
- Increased percentage of stroke patients discharged to rehabilitation
- Increased percentage of stroke patients managed on a designated stroke unit.

Risks/Barriers to Successful Implementation:

- Funding/time/motivation on behalf of necessary partners in implementing improvement initiatives
- Availability of current data which affects our ability to make decisions about where services should be offered and what issues are facing our community

- Community resources available for post-acute stroke patients
- Current stroke data sets are not linked to one another.

IHSP Priority: Decreasing Alternate Level of Care (ALC) Days

IHSP Priority Description:

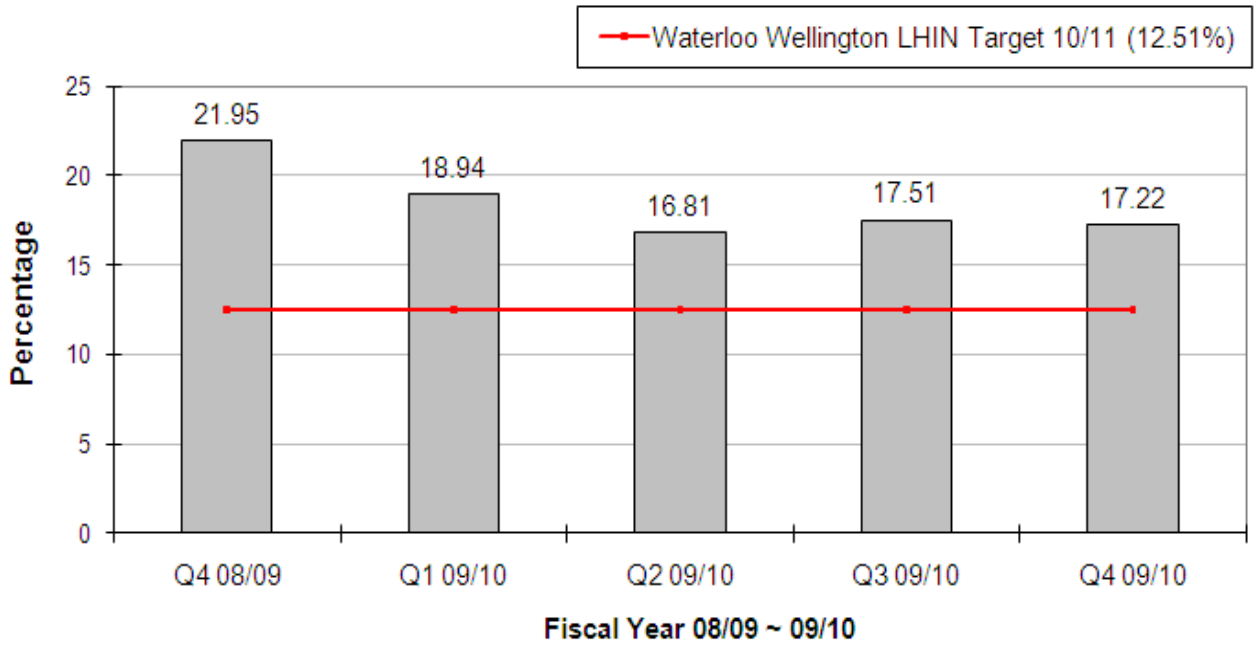
Within the WWLHIN, many patients wait in acute and post-acute hospital beds who no longer require the intensity of resources or services provided in those care settings (Acute, Complex Continuing Care, Mental Health or Rehabilitation). The hospital beds occupied by patients waiting for 'alternate levels of care' and who could be cared for more appropriately in another setting are referred to as "ALC Days".

ALC Days reflect the degree to which in-patient hospital resources are appropriately utilized, the ability to make effective transfers within the system, and the degree of hospital-community integration of the health system. As such, ALC Days are one indicator of system-level quality.

Current Status:

Overall, ALC Days in Waterloo Wellington have been decreasing, which is a positive trend.

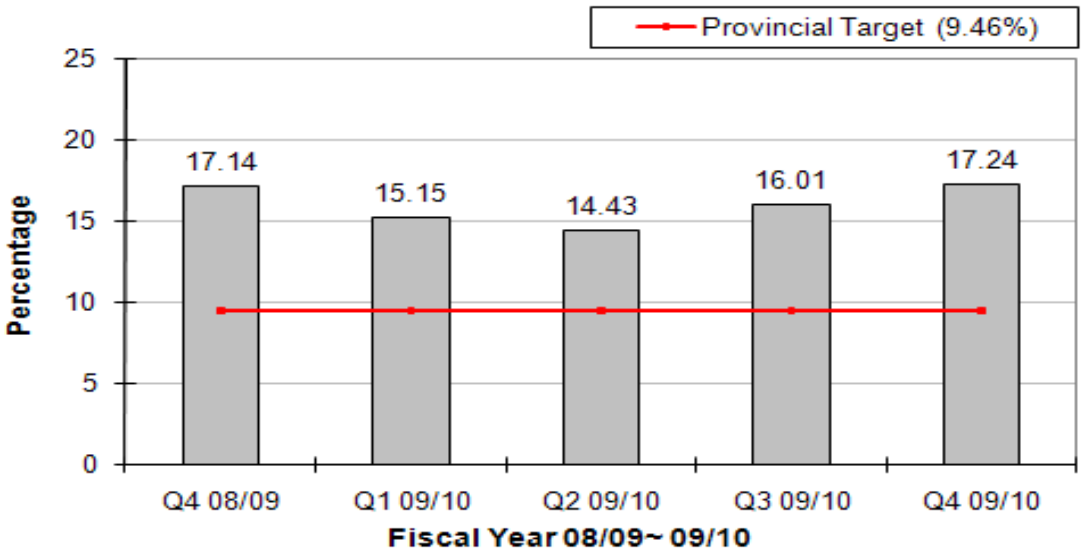
Figure 1.0 - Quarterly Performance WWLHIN % ALC Days[26]



[26] MOHLTC Stocktake Quarterly Report – August 2010

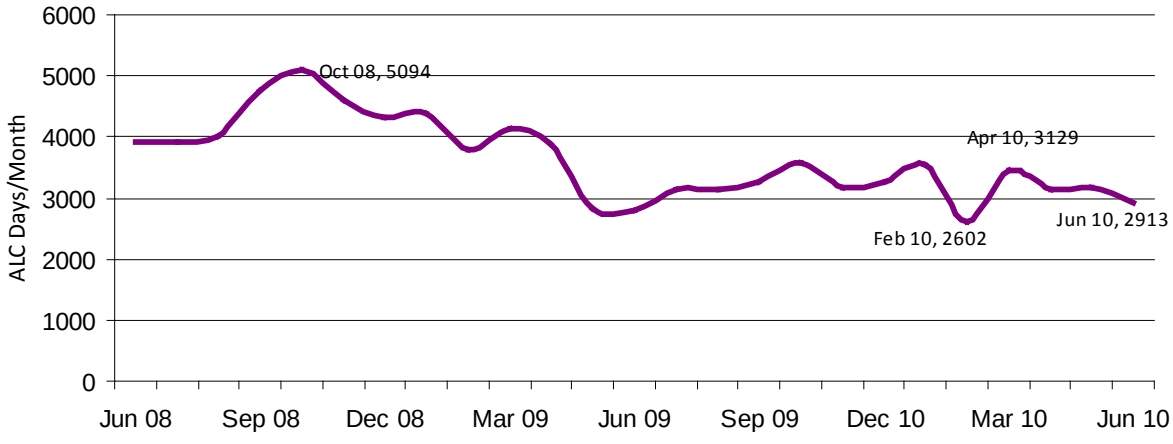
By late 2009 – 2010, WWLHIN performance on ALC days was roughly in line with the provincial average.

Quarterly Performance Ontario % ALC Days[27]



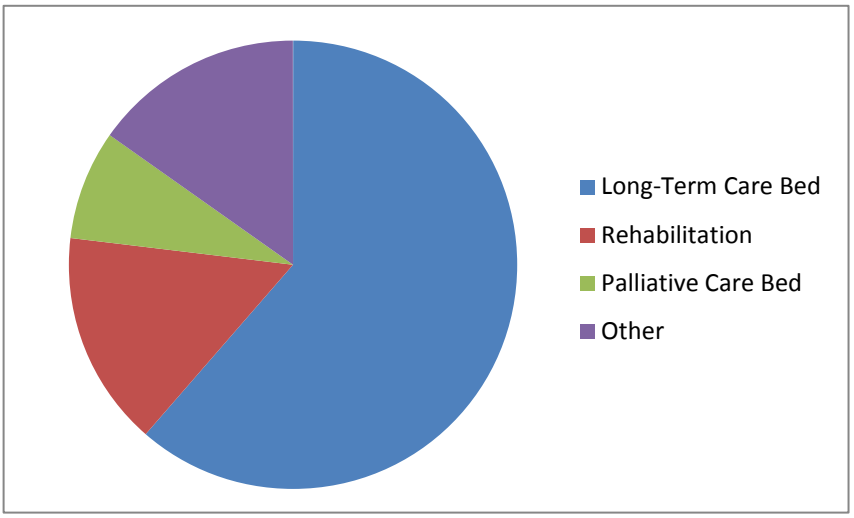
In absolute terms, the number of ALC Days in the WWLHIN is coming down; between June 2008 and June 2010 there was a 49% decrease in ALC Days. This means patients are able to move more quickly to more appropriate care settings, which is important for quality care because patients who wait too long in a hospital bed can experience a decline in their functional status, making placement in planned destinations even more challenging.

ALC days/month in the WWLHIN 2008 to 2010



[27] MOHLTC Stocktake Quarterly Report – August 2010

Where are these system blockages? Between April and August 2010 in the WWLHIN, approximately 61.4% of all ALC patients were waiting for placement to a long-term care home, 15.5% were waiting for a rehabilitation bed, 7.9% were waiting for a palliative bed.[28]



However, demand varies across the LHIN. For example, ALC patients in Guelph were more often waiting for rehabilitation or complex continuing care, while ALC patients in Waterloo Region were more often waiting for long-term care.

As of February 2010, long-term care occupancy in WWLHIN was at 99.3%, the highest in the province, while the average length of stay was one of the lowest at 2.6 years.[29] In addition, there are approximately eight LTC beds per 100 residents 75+, compared to a provincial rate of nine beds per 100 residents. Consistency with the provincial rate in the WWLHIN would require an additional 343 LTC beds.[30]

Long stay ALC patients (those waiting over 60 days) typically had behaviour issues (aggression, severe dementia, wandering), complex or heavy care needs, and/or the requirement of two-person lifts.[31]

Much has been accomplished across the WWLHIN over the past year to start to address these issues:

- A new Long Stay ALC Review Committee has been launched to assist with problem-solving discharge plans for complex patients

- Home First philosophy was rolled out across all WWLHIN hospitals resulting in a 60% drop in referrals to LTC placement assessment from hospital.

- Led by the Complex Continuing Care (CCC) Network, CCC services are being optimized through a single set of referral paperwork, with review underway to consider centralized intake for all WWLHIN CCC.

[28] Hospital Monthly ALC Reporting 2010
[29] Long-Term Care Home System Report, February 2010
[30] Long-Term Care System Report July 2010
[31] Long-Stay ALC patient reports 2009

- Aging at Home Year 3 initiatives have been implemented and continued expansion of Year 1 & 2 initiatives include:
    - 15 interim LTC beds at various existing LTC homes
    - Opening of a 34 bed interim LTC (iLTC) home in August and a second 35 bed iLTC home in January
    - One additional long stay LTC bed in addition to a planned LTC Home redevelopment
    - Restorative Care at 2 hospital sites
    - Further expansion of Geriatric Emergency Management (GEM) nurse program (two at each hospital) with additional work underway to optimize this program
    - Integrated Assisted Living Program (IALP) expansion to include additional urban sites and two rural sites. The IALP provided by WWCCAC is designed to support aging in place for IALP deemed WWCCAC clients, to deter their premature placement into long-term care homes and to prevent unnecessary visits to the emergency department
    - Expansion of community palliative care teams throughout WWLHIN.

Goals and Action Plans

Goals:

- Decrease the ALC days to meet the provincial target of 9.46%

Consistency with Government Priorities:

Decreasing Alternate Level of Care days is a key component of the provincial ED/ALC strategy.

Action Plans/Interventions:
Initiatives described below are also identified within other priority action plans because they relate not only to the IHSP priority area but are also intended to impact this priority.

Goal: Decrease ALC days to meet WWLHIN target of 12.51%

System Improvement Initiative	2011-2012	2012-2013	2013-2014
	Number indicates % completion of each of the system improvement initiatives anticipated in each of the three years		
In Hospital Strategies			
Implement and optimize Home First philosophy across the WWLHIN	25		
Implement initiatives aimed at decreasing ALC designation within 2 days of admission	25	25	25
Expand ED PIP to other areas beyond ED	25	25	
Seniors Friendly Hospital assessment and related system improvements	50	25	
CCC/Rehab provincial initiative re: roles and best practice	50	50	
Rehab Review	25	50	25
Community Strategies			
Open planned additional LTC capacity	50		
Clarify and implement the expanded role of the CCAC	75	25	
Develop, implement and optimize the 2011 - 2012 Transitional Care program	100		
Optimize coordinated access to community support services for seniors	25		
Implement initiatives related to Behavioural Support Services in conjunction with provincial initiatives	50	50	
Finalize and implement the Integrated Hospice Palliative Care Program	25	25	25
ABI program development and implementation	50		
Residents First quality improvement initiative	75		
Coordinated intake for Complex Continuing Care and Rehab Services	50	25	
Long Term Care home redevelopment	25	25	
Implement resource matching tools to facilitate referrals	25	25	25
Adult Day Program Review and implementation of related system improvements	25	50	25
Chronic Disease Prevention and Management			
Expand peritoneal dialysis to additional Long-Term Care homes	25	25	
Addictions and Mental Health			
Enhance addictions and mental health services for Seniors	25	50	

Measures of Success:

- Decreased percentage of ALC days to the provincial target of 9.46%
- Improved acute bed utilization
- Improved access to community services to enhance hospital discharge opportunities.

Barriers/Risks to Successful Implementation:

- ALC initiatives require a coordinated approach with involvement from many partners from different sectors. This causes challenges in implementing system-wide changes as there are different perspectives, funding and processes across the health care system
- Construction of new LTC homes and redevelopment of LTC homes may potentially be delayed
- Current Transitional Care Program ends on March 31, 2012
- Policy barriers around implementation of behavioural units in LTC homes

WWLHIN Operations

- Lack of options for complex clients who are identified as requiring care that is too heavy for LTC per the new regulations.

The following table presents planned expenditures for 2011-2012 and 2012-2013.

As the budget funding targets have not yet been confirmed, the WWLHIN has assumed a zero per cent increase in funding allocation. The WWLHIN Operations Spending Plan also assumes the following:

- 31 FTE's (including the French Language Services Coordinator position)
- Salaries and Wages are flat from the 2010 - 2011 planned expenditure levels
- Total Employee Benefits as 20% of Salaries and Wages
- Accommodation cost and LSSO shared service cost are both based on anticipated future costs as at the time of the ABP submission
- Ongoing funding for eHealth and French Language Health Services within LHIN Operations
- Renewal of one-time funding for ED Lead, ED/ALC Performance Lead, Critical Care Lead and Aboriginal Community Engagement.

Template B: LHIN Operations Spending Plan			
LHIN Operations Sub-Category ($)	2010/11 Budget	2011/12 Planned Expenses	2012/13 Planned Expenses
Salaries and Wages	2,451,904	2,660,521	2,660,521
Employee Benefits			
HOOPP	199,400	235,060	235,060
Other Benefits	251,981	297,044	297,044
Total Employee Benefits	***451,381***	***532,104***	***532,104***
Transportation and Communication			
Staff Travel	58,619	56,900	56,900
Governance Travel	11,337	12,000	12,000
Communications	72,999	80,000	80,000
Total Transportation and Communication	***142,955***	***148,900***	***148,900***
Services			
Accomodation	287,080	274,933	274,933
Advertising	44,900	30,820	30,820
Consulting Fees	187,375	71,865	71,865
LHIN Collaborative	50,000	50,000	50,000
Equipment Rentals	30,974	30,000	30,000
Governance Per Diems	137,485	138,450	138,450
LSSO Shared Costs	322,941	313,200	313,200
Other Meeting Expenses	50,500	55,000	55,000
Other Governance Costs	26,627	24,000	24,000
Printing & Translation	45,500	47,575	47,575
Staff Development	54,698	49,050	49,050
Total Services	***1,238,080***	***1,084,893***	***1,084,893***
Supplies and Equipment			
IT Equipment	-	29,300	29,300
Office Supplies & Purchased Equipment	65,099	65,000	65,000
Total Supplies and Equipment	***65,099***	***94,300***	***94,300***
e Health	600,000	600,000	600,000
LHIN Operations: Total Planned Expense (Note 1)	4,949,419	5,120,718	5,120,718
Annual Funding Target	4,949,419	5,120,718	5,120,718
LHIN Operations Target Variance	-	-	-
One-Time Funding			
Ontario Diabetes Strategy	25,000	-	-
ED Lead	75,000	75,000	75,000
ER/ALC Lead	100,000	100,000	100,000
Critical Care Lead	-	75,000	75,000
Aboriginal Community Engagement	5,000	5,000	5,000
French Language Services	61,700	-	-
Total One-Time Funding	***266,700***	***255,000***	***255,000***
One-Time Funding Target	***266,700***	***255,000***	***255,000***
One-Time Funding Target Variance	-	-	-

Note 1: Increase from 2010/11 budget to 2011/12 plan consists of:
$65,300 LHIN Operations approved increase allocated in 2010/11,
and $106,000 in annualized funding provided for French Language Health Services transferred from the Ministry in 2010/11.

WWLHIN Staffing Plan

Position Title	2010/11 Forecast	2011/12 Forecast	2012/13 Forecast
CEO	1	1	1
Senior Director	2	2	2
CIO	1	1	1
Administrative Professional	7	6	6
Planner	1	1	1
Analyst	1	2	2
Sr. Analyst	1	1	1
Lead	3	4	4
Manager	5	3	3
Sr. Manager	6	5	5
Coordinator	1	3	3
Director	1	1	1
French Language Services Co. (1)	1	1	1
Total FTEs	31	31	31

Note 1: French Language Services Co. role (+ 1 FTE) was transferred to the WWLHIN from the Ministry in 2010 - 2011.

WWLHIN Communications Plan

Objectives:

The ABP is one of two guiding documents that are critical to the work of the Waterloo Wellington LHIN. The other document is Working Together for a Healthier Future, Integrated Health Service Plan 2010 - 2013 (IHSP).

The IHSP guides the activities and accountabilities of local health service providers as described in the Local Health System Integration Act (LHSIA), 2006. Specifically, it provides an overview of the current health care system priorities, identifies system improvement initiatives and sets standards and targets for achievement. The 2010 - 2013 IHSP was developed in partnership with local health service providers and residents and builds on the progress made in the 2007 - 2010 IHSP.

The IHSP sets out eight priorities for transforming the local health system and identifies the related system improvement initiatives to be implemented over the three-year period of the plan.

The ABP is the annual action plan for implementing the improvement initiatives and achieving the targets set out in the IHSP. Through an overarching focus on enhancing quality care and improving patient safety, the WWLHIN's ABP demonstrates how progress will be made toward reaching the IHSP's strategic goals. Progress is measured through key indicators of gaps in system quality: emergency department visits and wait time information, and the nature of Alternate Level of Care patient needs.

The ABP outlines the key initiatives to be implemented and evaluated over the upcoming year. It also provides a framework for communicating to stakeholders the impact local decision making has on health care delivery in our communities.

Context:

Under LHSIA, 2006, and the Ministry-LHIN Performance Agreement (MLPA), LHINs are required to publish their Annual Business Plan to inform stakeholders about the LHIN's strategies and initiatives for addressing IHSP priorities. The Waterloo Wellington LHIN's ABP communication plan ensures that all stakeholders have full and easy access to our strategic and operational plans.

The document also includes an overview of the activities to support key provincial activities and a management plan to identify the future challenges faced by our health care system. LHINs are responsible for engaging health care providers, consumers, and the general public in the work that is required to build an accessible and sustainable quality health care system. The ABP also outlines LHIN funding requirements for the next three years with particular focus on the 2011 - 2012 fiscal year.

Target Audience:

Audiences include:

- MOHLTC
- Health Service Providers/Stakeholders
- Waterloo Wellington Health Service Provider Boards
- Waterloo Wellington LHIN Planning Partners
    - System Leadership Council
    - Community Council
    - eHealth Council
    - Addictions and Mental Health Network
    - Rural Health Network
    - Community Support Services Network
    - Hospice Palliative Care Network
    - Health Human Resources Committee
    - Physician Groups
    - All other established Care Networks
    - Public Health Leads
- Patients/Clients/Consumers/Residents
- Government stakeholders
    - Municipal
    - Regional
    - Provincial
    - Federal
- Other LHINs
- Health Service Providers Leadership and Front Line staff (including union leadership)
- Media.

Strategic Approach:

All 14 LHINs across the province will publicly release their ABP documents on the same day. In the morning, LHINs will notify their HSPs and stakeholder groups. In the afternoon, ABPs will be posted on individual LHIN web sites with the option to issue a local news release.

LHINs will also include the ABP Goals and Action Plan in all on-going communication and community engagement activities.

Tactics:

- Maintaining a consistent toolbox of strong communication vehicles, which include:
    - *2010 -2011 Annual Report*
    - *News Releases*
    - *eNewsletter*
    - *Bulletins*
    - *Waterloo Wellington LHIN Website*
    - *IHSP Public Dashboard*
- Communicating with Health Service Providers and Physicians
- Communication Partnership – LHIN Communication Leads
- Communication Partnership – Waterloo Wellington LHIN Communicators Group
- Maintaining strong local Government Relations
- System Leadership Council
- WWLHIN Community Council
- HPAC
- Communication between Network Steering Committees and Network Members
- Maintaining strong Media Relations
- Champions of Change – Information Session on Strategic Direction and Activities of the WWLHIN.

Waterloo Wellington **LHIN**

LIVE AND LIVE WELL IN WATERLOO WELLINGTON

Waterloo Wellington LOCAL HEALTH INTEGRATION NETWORK
50 Sportsworld Crossing Road, Suite 220 | Kitchener, Ontario N2P 0A4

T: 519 650 4472 F: 519 650 3155 Toll Free: 1 866 306 5446
Staff email: FirstName.LastName@lhins.on.ca
General email: WaterlooWellington@lhins.on.ca
Websites: www.wwlhin.on.ca | www.wwpartnersinhealth.ca

Ontario
Waterloo Wellington Local Health Integration Network