

Waterloo Wellington

Local Health Integration Network

Annual Business Plan 2012 - 2013

Table of Contents

Introduction and Context.....	3
Mission, Vision and Values	
Ontario's Action Plan for Health Care	
Corporate Objectives, Planning Principles and Governance Guideline	
The Transformation Agenda for Waterloo Wellington.....	7
1. Enhancing access to primary care	
2. Enhancing coordination & transitions of care for targeted populations	
3. Implementing evidence-based practice to drive quality	
4. Access to Care - Holding the gains	
5. Advancing system enablers to support needed changes	
French Language Service Plan	20
WWLHIN Operations	21
WWLHIN Communication Plan	24
Appendix A: Status of IHSP Initiatives.....	27
Appendix B : Background and Current Status of IHSP 2010-2013 Priorities	30

Introduction and Context

Mission and Vision

The Waterloo Wellington Local Health Integration Network (WWLHIN) is responsible for planning, integrating and funding health services to improve the health and wellbeing of approximately 750,000 residents in Waterloo Region, Wellington County, the City of Guelph, and the southern part of Grey County.

Early in 2012, the Waterloo Wellington Local Health Integration Network Board of Directors revisited its mission statement, vision and values. This work was completed in order to better align those statements with the expectations our residents have for the Network and the Network's health service providers, clinicians and staff. Our work was grounded in extensive research on international leading practices of health systems around the globe who have achieved results for their local residents. Our mission, vision, and values are the foundation upon which our strategic planning is built and will be the driving force behind all we do.

Mission

The Waterloo Wellington Local Health Integration Network exists to fulfill the following mission:

To lead a high-quality, integrated health system for our residents.

Vision

Our vision is a community in which residents have better health which will enable better futures.

Better Health – Better Futures

Core Value

As leaders of the health system, the Local Health Integration Network places ultimate value on:

Acting in the best interest of our residents' health and well-being.

We show this every day through:

- *Leading for results*
- *Achieving trust and confidence*
- *Making it happen*
- *Owning our decisions*

Ontario's Action Plan for Health Care and Our Plan for Waterloo Wellington

The initiatives that have been included in this Annual Business Plan are grounded in Ontario's Action Plan for Health Care as well as local health system planning and community engagement activities. They are designed to have the greatest impact on achieving our strategic priorities.

In the Action Plan for Health Care, the Minister of Health outlined specific areas of focus for the health system in the coming years:

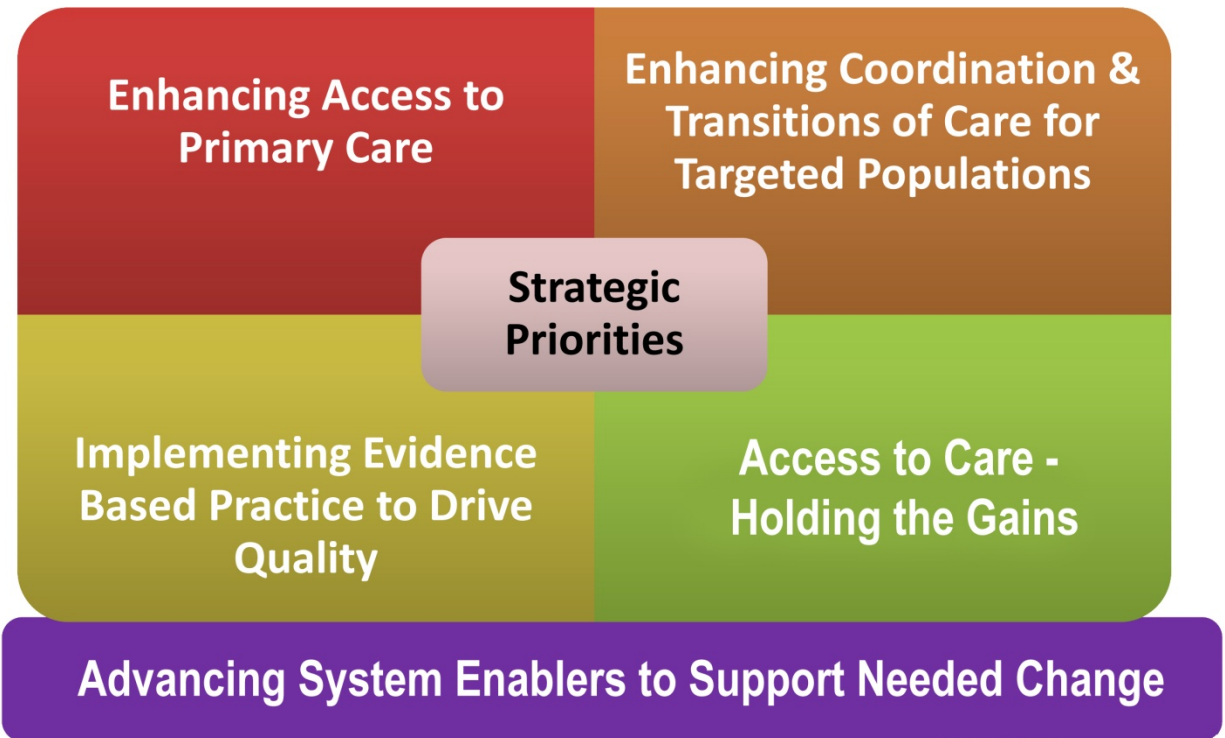
1. *Keeping Ontario Healthy* including specific strategies around health promotion related to childhood obesity, smoking cessation and cancer screening.
2. *Faster Access to Family Health Care* including specific strategies such as strengthening the role of family health care, improving access to primary care, increasing the use of house calls to support care needs, incorporating Family Health Care into the Local Health Integration Networks, and driving a focus on quality and best practice.
3. *Right Care, Right Place, Right Time* including specific strategies around timeliness and access, delivery of additional services in the community, integrated care processes, and a Seniors Health Strategy.

The Action Plan also comments on the need to maintain the gains that providers in Waterloo Wellington have made to date. These include such things as improvements in access to primary care and the significant decrease in wait times in areas such as MRI, cataract procedures and cardiac and cancer surgeries.

The fourteen Local Health Integration Networks have collaborated on translating the provincial Plan into local strategic priorities. As a result, four strategic priorities, reflective of the Ontario Plan and resonant at the local level, will be common across the fourteen Networks (see graphic on the next page). These four priorities are consistent with the feedback we consistently receive from local residents through our engagement activities – they are the priorities in our local community to improve our residents' health and well-being. They are not only reflected in this Annual Business Plan but will form the basis of our Integrated Health Service Plan 2013-2016.

Our local health system is transforming from a series of fragmented programs/services into a truly integrated system of care that is organized not around organizations, but around the resident. The timely achievement of results for our residents is dependent on being able to quickly remove barriers to change and support the transformation of the system by putting the health and well-being of residents first. Our priorities can be achieved more quickly by using enablers such as integrations, reallocation of funding, supporting those leaders in the system who share our objectives and supporting electronic health tools that our clinicians will use. As a result, we have also included a focus on enablers to ensure that the system commitment, structure, processes and tools across the continuum are in place to support transformation.

Waterloo Wellington will be moving forward immediately on actions related to the strategic priorities. Our Integrated Health Service Plan 2010-2013 is coming to a close and the overall plan has been implemented or is underway (see Appendix A). We have seen much success in the implementation of this plan (see Appendix B) and with the refinement of our strategy going forward, we will be continuing some of those initiatives and refining our focus toward specific outcomes for our local residents.



Corporate Objectives, Planning Principles

The specific initiatives that will be undertaken in each strategic priority will be guided by a set of Corporate Objectives and Planning Principles. We developed these by assessing what needs to happen locally to achieve results for our 750,000 residents and with advice from leaders of some of the best health systems in the world.

Corporate Objectives

The corporate objectives identify how the Waterloo Wellington Local Health Integration Network will achieve the outcomes related to the strategic priorities. They reflect how we will live out our mission, vision and values every day and how we will focus efforts to achieve outcomes for local residents.

- To provide transformational leadership to create a high-quality, integrated health system and collaborate with those who share this commitment.
- To commission quality health services in a sustainable health system.
- To integrate health services to achieve better health, better care and better value.
- To champion equity in population health and health outcomes.
- To attract and retain the best talent and create a great place to work.

Planning Principles

We will use planning principles to guide the identification and implementation of specific initiatives to address the strategic priorities. These principles have been developed based on both the principles outlined in Ontario's Action Plan for Health Care and research on global best practice in achieving results in health care transformation. We will use these principles when designing programs/services, pursuing integration opportunities and making funding decisions.

1. Start with the Triple Aim Objectives:
 - Better Health: improve the health of the population and health equity
 - Better Care: enhance the experience of care (including quality, access, and reliability)
 - Better Value: reduce, or at least control, the per capita cost of care
2. Focus on the 1-10% of health care users who utilize most of the health care resources – people with complex health and social care needs
3. Identify opportunities to shift capacity to primary and community care

The Transformation Agenda for Waterloo Wellington

The health and well-being of the roughly 750,000 residents in Waterloo Wellington will best be served by hospitals, community providers, mental health and addictions agencies, long-term care homes, physicians and thousands of clinicians and staff working towards the same objectives and outcomes under a common strategy.

The strategy and action plan outlined in this document is the single strategy and action plan for the local health system. This plan establishes the clarity and focus needed to achieve results for residents. All providers, clinicians and staff in the local health system are expected to align with the strategy so that residents may benefit from the outcomes laid out in the plan. Health service providers will be asked to submit their Board approved aligned strategy by the fall of 2012.

The Board of Directors of the Local Health Integration Network will work together with governors of Health Service Provider Agencies across Waterloo Wellington to ensure alignment with the strategy for the local health system.

The graphic on the next page summarizes each of the four strategic priorities and the enabling actions that together we will undertake to remove barriers and support the transformation of our local health system. The initiatives in each of the strategic priorities are inter-related as, due to the interconnected nature of the health system, initiatives identified in one strategic priority area often impact or relate to other priorities as well.

Waterloo Wellington Local Health Integration Network System Strategic Priorities 2012/2013



Enhancing Access to Primary Care

Improve timely access to primary care through:

- Connecting unattached patients to a primary care provider
- Understanding current access to primary care, and developing and implementing strategies to promote appropriate access to primary care

Develop and implement a primary care model for chronic disease prevention and management that targets frail and complex patients

Improve timely information sharing between providers to support family health care in knowing their patients' experience across the continuum of care and to improve health outcomes and system efficiency throughout the system

Develop a Primary Care Network to identify and address system needs and opportunities across the continuum of care to support improvements in primary care.



Enhancing coordination & Transitions of care for targeted populations

Ensure residents, especially those most in need, can effectively navigate transition points across the continuum of health care services:

- Implement the new WWCCAC client care model and fully realize their role as system navigator and trusted care connector

Integrate services to allow easier access and reduce handoffs within sectors and across the continuum of care

- Develop and implement integration plans for mental health, addictions, community support services, hospice palliative care program, acquired brain injury program



Implementing Evidence-Based practice to drive quality

Review hospital services and budgets as one system of acute care and reallocate resources to create a truly integrated and sustainable local health system.

- Develop a WWLHIN-wide system-level plan for acute care services including a vision for each acute care site.
- Develop a regional program accountability structure.
- Develop and implement regional programs:
 - Complete implementation planning for stroke with a target date for full implementation of April 1, 2013
 - Complete Phase II of planning for Rehabilitation Services with a target date for implementation of 2014.

Implement a regional life and limb policy that will ensure the transfer of critically ill patients to the closest, most appropriate care institution, in the most efficient, expedited and safest manner possible.

Develop and implement a falls prevention strategy across the continuum of care.

Implement evidence-based best practice wound protocol across the continuum of care.



Access to Care - Holding the gains

Timely monitoring of key performance metrics and immediate steps to address issues related to both the overall LHIN performance and also specific outliers as needed

Development of a publicly accessible performance dashboard to enable Health Service Providers and Boards of Directors to access a single source for accurate and timely information

Continue to establish shared best-practice initiatives across all Emergency Departments, Diagnostic Imaging Departments, and Surgical practices in WWLHIN to reduce wait times and protect the safety of local residents.

Publically report surgical and ED wait times to inform patient choice



Advancing system enablers to support needed changes

System level change management to accelerate changes that lead to high-quality, integrated health care services by:

- Governor-to-governor engagement to prioritize system integration
- Engaging key networks in the health system to lead change efforts
- Supporting those organizations and leaders who champion integration

Support implementation of the new patient-based funding formula through understanding the model, making information available, and setting expectations regarding quality of care and efficiency of services.

Work with community leaders across sectors to address the root causes of poor health for our residents.

Leverage clinical tools that have been proven to improve the patient experience and outcomes, enhance physicians' ability to deliver safe, effective care and reduce the number of complications and deaths:

- Spread the use of Clinical Connect across Waterloo Wellington
- Support the provincial Resource Matching & Referral initiative
- Develop a system-wide approach to central intake, referral, scheduling and booking
- Continue to support the use of telemedicine and OTN
- Establish a health system decision support unit
- Spread the use of common assessment tools in the community (OCAN, RAI, IAR)
- Leverage eHealth Ontario cSWO project outputs

June 2012

Strategic Priority #1: Enhancing Access to Primary Care



Strong primary care is a foundational component of a high-performing health system – one that achieves better health, better care and better value. Evidence shows that comprehensive, accessible primary care with a focus on addressing chronic disease prevention and management reduces avoidable emergency department visits and hospitalizations and improves overall population health.

Ontario's Action Plan for Health Care recognizes family health care as the hub of the health care system. This has been referred to as the person's medical home-base where they go for primary care, information, advice, and access to needed care and supports from the broader system of care. To fully realize the benefits of having family health care as the hub, we will need to ensure residents have that home-base attachment to a primary care provider or team and that primary care is well connected with the full continuum of care. This will facilitate connecting patients with needed services/care and primary care providers will have a full understanding of their patient's health care throughout these transitions with other providers.

Our Primary Care Physician Lead, working in concert with primary care providers across Waterloo Wellington, will develop an understanding of the needs and pressures in the community by engaging stakeholders including primary care providers, WWCCAC, hospitals, community services and long-term care homes. This engagement will be a key input as we work together to connect primary care effectively within the overall continuum of health care services.

Key initiatives to achieve our strategic priority:

1. Improve timely access to primary care through:
 - a. Connecting unattached patients to a primary care provider
 - b. Understanding current access to primary care, and developing and implementing strategies to promote appropriate access to primary care
2. Develop and implement a primary care model for chronic disease prevention and management that targets frail and complex patients
3. Improve timely information sharing between providers to support family health care in knowing their patients' experience across the continuum of care and to improve health outcomes and system efficiency throughout the system
4. Develop a Primary Care Network to identify and address system needs and opportunities across the continuum of care to support improvements in primary care.

Expected outcomes for Waterloo Wellington Residents:

(Indicators and targets to be confirmed)

Through implementation of the initiatives, local residents can expect:

- Increased number of residents who are attached to a primary care provider
- Reduced emergency department visits for non-urgent cases that could have been seen in a primary care setting
- Reduced hospitalizations for conditions that could be better managed in the community

Other indicators are being considered provincially, focused on access to primary care, emergency department avoidance, same day access for urgent care needs, and establishing engagement structures to support integration.

We are currently considering how to measure success in the above and will work with our primary providers at the appropriate time to determine the most effective indicators.

Potential risks/barriers to successful implementation of the initiatives:

- Clarity of the role of family care as the hub of the health care system will necessitate providers to understand and act upon this clarified role and related expectations
- Improving the health of the population is a long term strategy. Results will be seen over the mid- to longer- term and will require commitment and patience to experience the results.
- To see the benefits of improved communication amongst providers, changes to work flows are required. Achieving the necessary changes in practice behavior in all settings can be challenging and pose a risk to achieving the full benefits of the initiatives.

Key enablers to achieve outcomes:

- Expand the use of Electronic Medical Records in primary care as well as in specialist offices.
- Electronic sharing of clinical information to enable care providers from across the continuum of care to have up-to-date patient information and improve outcomes.
- Health system management data and analysis that is closer to 'real time' to assist health system managers in deploying effective services focused on local needs.
- Primary Care Physician Lead to assist in connecting with all types of primary care providers.
- All-of-community approach to addressing the Social Determinants of Health and Chronic Disease Prevention and Management to improve health outcomes for residents.

Strategic Priority #2: Enhancing Coordination & Transitions of Care for Targeted Populations



Waterloo Wellington residents tell us that they do not always know where to go to get the care that they need. Similarly, we hear from providers that even when they know what care is needed, they often do not know the best place to send patients. In the transitions, or hand offs, between providers there lies great risk to quality of care that can often lead to repeat use of the health care system, whether it be emergency department visits or readmissions, or gaps in care which could negatively impact health outcomes.

Navigating the complex health care system is especially difficult for people that have the most complex needs. We now have local data that shows approximately 1,400 residents, or one per cent of the population who accessed health care services in 2009/10 accounted for upwards of 20 per cent (\$145M) of total health care costs in the same year. Further, 8,400 residents, or five per cent of total users accounted for almost \$330M in total health care costs. These 1-10% of the population represent the most complex and frail in our community – a group that requires greater assistance in accessing the right care at the right place at the right time.

Transitions in care has been highlighted as a top priority for improvement in a number of recent reports. The Change Foundation's 2012 report titled: "Loud and Clear – Seniors and caregivers speak out about navigating Ontario's healthcare system" identifies hand-offs between providers as a priority identified by residents. In addition, the Report of the Avoidable Hospitalization Advisory Panel, November 2011 states that: "Hospital readmissions can be seen as a signal of system failure: they often occur because of gaps in care and communications as patients transition from the hospital setting to the next setting of care (home, community care, long-term care home, etc...), and reflect the complexities of the transitions in a health care system in which care is delivered by multiple health service providers with different accountabilities." The same report estimates that in 2008/09 unplanned 30-day readmissions accounted for \$705 million in Ontario hospital costs.

The Report of the Avoidable Hospitalization Advisory Panel highlights several key components to ensuring effective transitions for patients:

- Better planning for discharge
- Improved communication between clinicians in different settings as well as between clinicians and patients
- Medication reconciliation and management when the patient returns home
- Patient and caregiver education, and
- Timely primary care follow-up in the community

The initiatives in this strategic priority as well as those in enhancing access to primary care and implementing evidence-based practice to drive quality are all critical components to transforming the way that residents access care. By integrating care both within sectors and across the continuum of care for specific patient populations, we will improve the patient experience, reduce the risk of poor health outcomes, and improve value for money.

Key initiatives to achieve our strategic priority:

1. Ensure residents, especially those most in need, can effectively navigate transition points across the continuum of health care services:
 - Implement the new WWCCAC client care model and fully realize their role as system navigator and trusted care connector
2. Integrate services to allow easier access and reduce handoffs within sectors and across the continuum of care
 - Develop and implement integration plans for mental health, addictions, community support services, hospice palliative care program, acquired brain injury program.

Expected outcomes for Waterloo Wellington Residents:

(Indicators and targets to be confirmed)

Through implementation of the initiatives, local residents can expect:

- Reduced readmission rates (Readmission within 30 Days for Selected CMGs)
- Reduced repeat unscheduled ER visits within 30 Days for mental health conditions
- Reduced repeat unscheduled ER visits within 30 Days for substance abuse conditions
- Percentage of Alternate Level of Care days meeting provincial target
- 90th percentile wait time (days) for home care services (community setting) meeting provincial target

Potential risks/barriers to successful implementation of the initiatives:

- As individuals remain in the community longer, community providers are providing service to higher acuity patients; community services may not be designed to support the level of acuity that they are seeing within their organizations (e.g. human resources, program design, etc.).
- Providers invoke privacy legislation as a barrier and/or will not voluntarily change their processes.
- Dependency on the WWCCAC to fully realize its role as system navigator and trusted quality care connector.
- Proposed solutions, such as additional navigators, may add unnecessary steps/handoffs to the patient experience as opposed to making it easier.

Key enablers to achieve outcomes:

- Health Service Provider boards prioritizing system integration initiatives as exemplified by board motions and related strategic planning.
- Best practice knowledge of quality improvement methodologies to improve the resident experience and eliminate waste in the system.
- Standardization of reporting practices and business tools used across sectors.
- Integrated Assessment Repository (IAR) and common assessment for community providers.
- Health system management data and analysis that is closer to 'real time' assists health system managers in ensuring that deployed services are effectively focused on local needs.
- Electronic sharing of clinical information at point of care enables care providers from across the continuum of care to have up-to-date patient information and improves outcomes.

Strategic Priority #3: Implementing Evidence-Based Practice to Drive Quality



The nature of healthcare has changed over the last several decades. It has become progressively more specialized and increasingly relies on expensive equipment, specialized treatments, and highly skilled care professionals who are often in short supply. We have been experiencing a growing mismatch between the needs of patients and the design of the health system.

In order to ensure residents receive high quality care when they need it, the health system must be redesigned to catch up to our current reality. There are simply not enough resources to provide every service in every possible location, nor is it safe to do so. We must implement the growing body of best practice evidence which points to the need to cluster care where there is the critical mass of patients and caregivers with the right skills to provide the needed care, safely and effectively.

The WWLHIN together with its hospital partners recognizes this challenge and has begun a process to develop a comprehensive acute care services plan to ensure that the acute care needs of the residents of Waterloo Wellington continue to be met in as safe and efficient manner as possible with care as close to home as can be accomplished within our resources.

During this fiscal year the WWLHIN will be working with its hospital partners and stakeholders to develop a plan for acute care services that identifies a vision and a purpose for each acute care site. A governance and accountability model will be developed that will allow for the deployment of regional programs that span traditional organizational and geographic boundaries to ensure that we are delivering a high quality and consistent level of care to the residents of Waterloo Wellington.

We will also be looking across the continuum of care for the implementation of best practice to ensure that residents achieve better health through the delivery of evidence-based, best practice care.

Key initiatives to achieve our strategic priority:

1. Review hospital services and budgets as one system of acute care and reallocate resources to create a truly integrated and sustainable local health system.
 - a. Develop a WWLHIN –wide system-level plan for acute care services including a vision for each acute care site.
 - b. Develop a regional program accountability structure.
 - c. Develop and implement regional programs:
 - i. Complete implementation planning for stroke with a target date for full implementation of April 1, 2013
 - ii. Complete Phase II of planning for Rehabilitation Services with a target date for implementation of 2014.
2. Implement a regional life and limb policy that will ensure the transfer of critically ill patients to the closest, most appropriate care institution, in the most efficient, expedited and safest manner possible.
3. Develop and implement a falls prevention strategy across the continuum of care.
4. Implement evidence-based best practice wound protocol across the continuum of care.

Expected outcomes for Waterloo Wellington Residents:

(Indicators and targets to be confirmed)

Through implementation of the initiatives, local residents can expect:

- Reduced readmission rates
- 100% of stroke patients are treated on a designated stroke unit
- Reduced 30-day stroke mortality rate to the provincial benchmark of 14.3%

Other indicators are being considered provincially, focused on identifying high priority issues that require consistent coordinated response (falls, pressure ulcers) to minimize or eliminate adverse events and tracking key indicators in multiple care settings.

Potential risks/barriers to successful implementation of the initiatives:

- Gaining the necessary stakeholder support to ensure a full and smooth implementation.
- Resources and organizational capacity to manage potentially large scale change.

Key enablers to achieve outcomes:

- Clinical leadership in design and implementation of needed change
- Dedicated resources to provide the leadership needed for a successful implementation of the stroke review recommendations
- Dedicated resources to enable the completion of the rehab services planning and implementation

Strategic Priority #4: Access to Care - Holding the Gains



The Waterloo Wellington health system has achieved significant accomplishments in key areas such as reducing the number of days patients spend in hospital when requiring an alternative level of care, and decreasing wait times for emergency department care, diagnostic and surgical procedures. As organizations identify and pursue new strategic priorities, it can be a challenge to ensure that past initiatives are not sidelined and any achievements or gains lost. However, the WWLHIN and health service providers recognize the importance of holding the gains in these areas and achieving established provincial benchmarks. Maintaining results will continue to be part of the performance management process between the WWLHIN and health service providers in accordance with our accountability agreements. In addition, we will work with the WWLHIN ED Physician Lead, networks, working groups and committees to ensure proven ideas are spread across the system and that performance is improved and maintained.

Key initiatives to achieve our strategic priority:

1. Timely monitoring of key performance metrics and immediate steps to address issues related to both the overall LHIN performance and also specific outliers as needed
2. Development of a publically accessible performance dashboard to enable Health Service Providers and Boards of Directors to access a single source for accurate and timely information
3. Continue to establish shared best-practice initiatives across all Emergency Departments, Diagnostic Imaging Departments, and Surgical practices in WWLHIN to reduce wait times and protect the safety of local residents.
4. Publically report surgical and ED wait times to inform patient choice

Expected outcomes for Waterloo Wellington Residents:

(Indicators and targets to be confirmed)

Meet the provincial benchmark for the following:

- 90th Percentile Emergency Department (ED) Length of Stay for Admitted Patients
- 90th Percentile Wait Times for Diagnostic MRI Scan
- 90th Percentile Wait Times for Diagnostic CT Scan
- 90th Percentile Wait Times for Hip Replacement Surgery
- 90th Percentile Wait Times for Knee Replacement Surgery
- 90th Percentile Wait Times for Cancer Surgery
- 90th Percentile Wait Times for Cardiac Bypass Surgery
- 90th Percentile Wait Times for Cataract Surgery
- 90th Percentile Wait Time for WWCCAC In Home Services - Application from Community Setting to First WWCCAC Service

Potential risks/barriers to successful implementation of the initiatives:

- Provincial criteria for recovery of one-time funding (P4R) have historically been finalized after the fiscal year has ended. This has created uncertainty for hospitals and, in some cases, impacted the timing of hospitals using revenue to address ED operational priorities
- Emergency physician funding models that fall outside of the purview of the LHIN.
 - Mitigation to date has been to encourage ED groups to maximize their understanding and find ways that align system interests (lower ED wait times) with remuneration incentives for physicians.
- Other WWLHIN priority projects that change clinical pathways implicating EDs.
- Wide variation in performance across multiple ED sites.

Key enablers to achieve outcomes:

- Use of the Waterloo Wellington Emergency Services Network to build common understanding amongst network providers and to develop a system-wide approach to the delivery of emergency care.
- Participation at provincial tables with respect to defining and establishing criteria for Pay for Results (P4R) payments and recoveries. This will reduce hospital hesitation around the treatment of one-time funding to support programs, stabilizing the context for improvement and better enabling innovative ideas.
- WWLHIN ED Physician Lead to assist in developing understanding on how to best leverage physician funding models
- Use of the Waterloo Wellington MRI/CT working group to build common understanding around maximizing the new capacity in MRI and CT service.
- Regular meetings with each hospital ED leadership team.
- Frequent, structured communication amongst partners to establish shared understanding and trust.
- Effective program design across multiple stakeholders.
- Use of pilots to explore new ways of providing effective care including the potential for new community-based clinics.

Advancing system enablers to support needed changes



Our local health system is transforming from a series of fragmented programs/services into a truly integrated system of care that is organized not around organizations, but around the resident. The timely achievement of results for our residents is dependent on being able to quickly remove barriers to change and support the transformation of the system by putting the health and well-being of residents first. Actions such as funding reform, an increased focus on accelerating integration and the adoption of appropriate eHealth tools that clinicians want and will use are all examples of actions that are underway both locally and provincially.

The Waterloo Wellington Local Health Integration Network Board has also approved several Corporate Objectives designed to more quickly enable the needed changes. For instance, the WWLHIN Board will provide transformational leadership to create a high-quality, integrated health system and collaborate with those who share this commitment. We will undertake to specifically support those leaders, clinicians and organizations that put the health and well being of our residents first by engaging in activities that impact the Triple Aims of Better Health, Better Care and Better Value for taxpayer dollars. We will also take actions to protect the same on behalf of our 750,000 residents by utilizing our authorities to their full potential to ensure that necessary changes are made.

Key initiatives to enable needed change:

1. System level change management to accelerate changes that lead to high-quality, integrated health care services by:
 - a. Governor-to-governor engagement to prioritize system integration
 - b. Engaging key networks in the health system to lead change efforts
 - c. Supporting those organizations and leaders who champion integration
2. Leverage clinical tools that have been proven to improve the patient experience and outcomes, enhance physicians' ability to deliver safe, effective care and reduce the number of complications and deaths :
 - a. Spread the use of Clinical Connect across Waterloo Wellington
 - b. Support the provincial Resource Matching & Referral initiative
 - c. Develop a system-wide approach to central intake, referral, scheduling and booking
 - d. Continue to support the use of telemedicine and OTN
 - e. Establish a health system decision support unit
 - f. Spread the use of common assessment tools in the community (OCAN, RAI, IAR)
 - g. Leverage eHealth Ontario cSWO project outputs
3. Work with community leaders across sectors to address the root causes of poor health for our residents.
4. Support implementation of the new patient-based funding through understanding the model, making information available, and setting expectations regarding quality of care and efficiency of services.

Expected outcomes for Waterloo Wellington Residents:

Successful implementation of these enabling initiatives will support the other four strategic priorities in achieving their outcomes.

Potential risks/barriers to successful implementation of the initiatives:

- Resources required to advance system enablers
- Information systems across the system are not compatible
- Complexity of building a community-wide plan for meaningful change to the social determinants of health
- Implementing the necessary process improvements to garner the benefits of eHealth opportunities
- Provincial eHealth initiatives not progressing as quickly as the need and demand locally

Key enablers to achieve outcomes:

- Engagement at the governor level
- Skill, knowledge and expertise of health service providers
- Diverse stakeholder interest in addressing social determinants of health
- Knowledge of local data regarding social determinants of health to assist with identifying solutions
- Opportunity to address known gaps in information/communication through existing and evolving technology

French Language Service Plan

The WWLHIN has 15,300 Francophone residents¹ according to the latest data available through the Health Analytics Branch, Ministry of Health and Long-Term Care. While there are no areas in the WWLHIN geography 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. Our French Language Services (FLS) Coordinator is integrated into all activities of the LHIN to ensure that our work reflects the needs of our local 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 2012-2013 includes:

- Continue to monitor, assist and support 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 that offers services in French to the WWLHIN residents.
- Continue to work in partnership with the Waterloo Wellington Hamilton Niagara (WWHN) French Language Planning Entity to develop a local Portrait of the Francophone Community as well as the health status of that community.
- Participate in inter-ministerial work groups to facilitate access to FLS within the health sector particularly in regard to special needs for students in the French schools.
- In partnership with the Planning Entity, coordinate community engagement activities with the francophone community in order to better address their health care needs.
- Ensure that FLS are part of any new initiatives such as the LHIN wide telemedicine project that is under development.
- Consider the advice of the WWHN French Language Planning Entity in local planning.
- In partnership with Public Health agencies in the WWLHIN, develop an action plan to ensure that the Francophone community is part of the 'Healthy Community' program of those agencies.
- Continue to foster partnerships within the WWLHIN system to ensure Francophone residents have equitable access to services that will result in improved health status.

The work planned for 2012-2013 will reflect the changes in the environment within our LHIN such as the work and recommendations of the Planning Entity and the changes in the demography of the Francophone community which now has a large component of new immigrants and visible minorities.

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

WWLHIN Operations

In addition to the need to accelerate system transformation, the Waterloo Wellington Local Health Integration Network is taking on additional accountabilities previously performed by Ministry of Health and Long-Term Care staff. The Waterloo Wellington Local Health Integration Network is expected to accomplish this while also taking a 5% budget reduction and a 10% reduction in its Executive Office budget.

The Waterloo Wellington Local Health Integration Network is committed to continuing to achieve better results than any past health system organization in this area by being innovative in how it carries out its work. We continue to leverage the back office partnership we have with the other 14 LHINs in the form of the LHIN Shared Service Organization (LSSO) and the Local Health System Integration Network Collaborative.

We are also undertaking a restructuring of our organization that is aligned with our strategy and enables us to live our new mission, achieve our vision, better live our core values and achieve our Corporate Objectives. The WWLHIN Operations Spending Plan assumes the following for 2012/13:

- 27 FTEs
- Total Employee Benefits as 20% of Salaries and Wages
- Total Governance Costs are flat from the 2011/12 allocation
- Accommodation cost and LSSO shared cost are both based on anticipated cost decreases as at the time of ABP submission

Table 1 - WWLHIN Operations Spending Plan				
LHIN Operations (\$)	2011/12 Actual	2012/13 Plan	2013/14 Outlook	2014/15 Outlook
Salaries and Wages	2,885,407	3,080,854	3,080,854	3,080,854
Employee Benefits				
HOOPP	267,312	278,868	278,868	278,868
Other Benefits	365,875	282,832	282,832	282,832
Total Employee Benefits	633,187	561,700	561,700	561,700
Transportation and Communication				
Staff Travel	46,996	63,741	63,741	63,741
Governance Travel	12,433	13,068	13,068	13,068
Communications	71,736	64,652	64,652	64,652
Others			-	-
Total Transportation and Communication	131,165	141,461	141,461	141,461
Services				
Accommodation	409,039	336,719	336,719	336,719
Community Engagement	55,353	66,800	66,800	66,800
Consulting Fees	354,428	208,465	208,465	208,465
Governance Per Diems	116,150	135,000	135,000	135,000
LSSO Shared Costs	535,025	341,620	341,620	341,620
Other Meeting Expenses			-	-
Other Governance Costs	22,267	26,382	26,382	26,382
Staff Development	28,921	49,050	49,050	49,050
Other Services	63,463	95,075	95,075	95,075
Total Services	1,584,646	1,259,111	1,259,111	1,259,111
Supplies and Equipment				
IT Equipment	36,242	39,720	39,720	39,720
Office Supplies & Purchased Equipment	85,809	61,873	61,873	61,873
Other S & E			-	-
Total Supplies and Equipment	122,051	101,593	101,593	101,593
Capital Expenditures				
LHIN Operations: Total Planned Expense	5,356,456	5,144,719	5,144,719	5,144,719
Operations (Base)	4,419,719	4,198,719	4,198,719	4,198,719
Behavioral Support Ontario	57,000	-	-	-
eHealth Ontario	600,000	510,000	510,000	510,000
Aboriginal Community Engagement	5,000	5,000	5,000	5,000
ED Lead	75,000	75,000	75,000	75,000
ED/ALC, Performance Lead	100,000	100,000	100,000	100,000
French Language Services	106,000	106,000	106,000	106,000
Critical Care Lead	75,000	75,000	75,000	75,000
Primary Care Lead	21,875	75,000	75,000	75,000
Annual Funding Target	5,459,594	5,144,719	5,144,719	5,144,719
Operating Surplus (Shortfall)	103,138	-	-	-

Table 2 - WWLHIN Staffing Plan				
Position Title	2011/12 Forecast	2012/13 Plan	2013/14 Outlook	2014/15 Outlook
LHIN Operations				
CEO	1	1	1	1
CSO		1	1	1
Senior Director	2	1	1	1
Director	1	1	1	1
Senior Manager	4	3	3	3
Manager	4	4	4	4
Executive Assistant	2	1	1	1
Administrative Assistant	3	4	4	4
Lead	3	2	2	2
Communication Specialist	1	1	1	1
Community Engagement Coordinator	1	1	1	1
Planner	1	0	0	0
Senior Planner		1	1	1
Analyst	3	3	3	3
Corporate Coordinator		1	1	1
Sub-total	26	25	25	25
Initiatives				
eHealth, i.e. eHealth Lead, Administrative Assistant, Project Manager	3	1	1	1
French Language Coordinator	1	1	1	1
ED/ALC Performance Lead	1			
Sub-total	5	2	2	2
GRAND TOTAL	31	27	27	27

WWLHIN Communication Plan

The Annual Business Plan (ABP) is one of two documents that guide the work of our Local Health Integration Network and our health service providers. Under the Local Health Systems Integration Act (LHSIA) 2006, and the Ministry-LHIN Performance Agreement (MLPA), Local Health Integration Networks are required to publish an Annual Business Plan to inform stakeholders about the local strategies and initiatives that will be undertaken to achieve the strategy outlined in the local health system's Integrated Health Service Plan.

Our current Integrated Health Service Plan 2010-13 (IHSP) identified eight priorities of focus. Within each of the eight priorities, a number of system improvement initiatives were developed with stakeholders and implemented leading to improved results for our residents in those specific priority areas. However, more needs to be accomplished. The introduction of Ontario's Action Plan for Health Care, the Excellent Care for All Act and actions of recent months such as the introduction of a patient-based funding model are all being done in support of getting on with the necessary transformation of our system.

As a result, the Waterloo Wellington Local Health Integration Network is using this Annual Business Plan immediately rather than waiting for April 1, 2013 for implementation. We are moving to address the four strategic priorities within the strategic context of our new mission, vision, and core value.

We are currently developing a communications, marketing and rebranding plan to ensure our residents, clinicians and health service provider staff better understand the local strategy and the key priorities to improve the health and well-being of our 750,000 local residents. We will be implementing this plan over the summer and fall of 2012.

Target Audiences

The WWLHIN deals with many stakeholder audiences, each with its own, and often differing, understanding of the health care system and the role of the LHIN in planning, integrating and funding the system. This needs to change and alignment is key to success.

Stakeholders can be grouped in several categories and sub-categories:

- Local Residents
- Local Health Care System Providers
 - Boards of hospitals, community service agencies, community health centres, Community Care Access Centre, mental health and addictions agencies and long-term care homes
 - Physicians, nurses, other clinicians and staff
 - Administrators of hospitals, community service agencies, community health centres, Community Care Access Centre, mental health and addictions agencies and long-term care homes
 - Organizations that influence the health and well-being of our residents and the social determinants of health
 - Municipalities
 - Public Health
 - School Boards
 - Private Sector
- Ministry of Health and Long-Term Care
- Internal to the WWLHIN
 - LHIN Board of Directors
 - LHIN Senior Leadership Team
 - LHIN Staff
- WWLHIN Advisory and Reference Groups
 - LHIN Health System Leadership Council
 - Local Health Professionals Advisory Council
 - Various Networks (Addictions and Mental Health, Community Support Services, Geriatric Services, Emergency Services, etc.)
 - Local Community Council
 - Local Health Integration Network eHealth Steering Committee
- Other External Stakeholders
 - MPPs
 - Members of Council
 - Media

Key Messages

We are currently developing a communications, marketing and rebranding plan to ensure our residents, clinicians and health service provider staff better understand the local strategy and the key priorities to improve the health and well-being of our 750,000 local residents. We will be implementing this plan over the summer and fall of 2012.

Our key messages will focus on the following:

- The Waterloo Wellington Local Health Integration Network's mission, to lead a high-quality, integrated health system, will be realized in 2012/13 through the implementation of strategic priorities and related key initiatives.
- With a focus on our vision of "Better Health – Better Futures" and driven by the core value of "acting in the best interest of our residents' health and well-being", the WWLHIN will generate better health, better care and better value for taxpayers' dollars.
- The health system strategic priorities include: Enhancing Access to Primary Care, Enhancing Coordination and Transitions of Care for Targeted Populations, Implementing Evidence Based Practice to Drive Quality and Access to Care - Holding the Gains.
 - Enhancing access to primary care means helping more residents find a primary care provider, providing timely access to primary care when needed, and improving connections between primary care and the rest of the system.
 - Enhancing Coordination and Transitions of care for targeted populations means integrating services to make it easier for residents to effectively navigate the care system and access the right care, in the right place, at the right time.
 - Implementing Evidence Based Practice to Drive Quality means changing the way we currently provide care to ensure residents receive high quality care that is based in evidence, focused on the patient, and provides the best possible outcome.
 - Access to Care - Holding the Gains means maintaining the progress we have made to date in areas such as wait times for Emergency Departments, CT, MRI, cardiac care, cataract and cancer surgery.
- Above all, the Local Health Integration Network is focused on protecting and improving the health and well-being of our residents. Because of the LHINs, for the first time, providers are being held to account to achieve quality outcomes, improve access to care, and ensure value for taxpayer dollars.
- We will undertake to specifically support those leaders, clinicians and organizations that truly put the health and well being of our residents first by actions that impact all the Triple Aims of Better Health, Better Care and Better Value for taxpayer dollars.
- We will also take actions to protect the same on behalf of our 750,000 residents by utilizing our authorities to their full potential where barriers to change or self-interests present themselves.

Appendix A: Status of IHSP Initiatives

The following activities from the WWLHIN's Integrated Health Service Plan (IHSP) 2010-13 have been completed:

Improving Patient Safety and Enhancing Quality of Care

- ✓ Developed and implemented a model that improves a coordinated access to community support services for seniors (Easy Coordinated Access Project).
- ✓ Included patient safety and quality of care expectations in accountability agreements.
- ✓ Implemented a central image and report repository amongst hospitals in Waterloo Wellington and Hamilton Niagara Haldimand Brant (Shared Diagnostic Imaging Repository (DI-r) project).

Improving wait times for MRI exams

- ✓ Reassessed and continue to pursue additional MRI capacity.
- ✓ Implemented additional MRI capacity in the WWLHIN.

Improving access to emergency department (ED) care

- ✓ Implemented Critical Care Surge Capacity recommendations.

Improving chronic disease prevention and management

- ✓ Established a Regional Diabetes Centre and related programs.
- ✓ Implemented a comprehensive bariatric program.
- ✓ Developed a comprehensive framework for the prevention and management of chronic diseases.
- ✓ Expanded the Alpha-FIM (rehabilitation readiness assessment) across the WWLHIN.
- ✓ Expanded the dysphasia screening tool to acute care facilities across the WWLHIN.
- ✓ Expanded peritoneal dialysis to long term care homes
- ✓ Expanded smoking cessation initiatives across the WWLHIN.

Improving access to primary care

- ✓ Expanded Family Health Teams, Community Health Centres and Nurse Practitioner Led Clinics services. (Mango Tree FHT, Waterloo Region NP Clinic)
- ✓ All recommendations of the Rural Health Care Review have either been completed or are in progress.
- ✓ Expanded and provided education opportunities for vulnerable populations and youth.
- ✓ Expanded tele-medicine services

Decreasing alternate level of care (ALC) days.

- ✓ Identify opportunities for LTC homes to accept higher acuity level residents.
- ✓ Implemented information system that enables monitoring of outcomes of care in long-term care homes (RAI MDS 2.0).
- ✓ Launched 12 transitional living beds for Acquired Brain Injury.
- ✓ Expanded the Integrated Assisted Living Program pilot for seniors.
- ✓ Enhance mental health services for seniors.
- ✓ Launched a 33 bed supportive housing program.
- ✓ Expanded supportive living services for seniors.
- ✓ Opened 298 long-term care beds
- ✓ Completed LTC home redevelopment at Hilltop Manor

Improving access to, and coordination of, addictions and mental health services

- ✓ Opened 48 additional addictions supportive housing units to increase social and health outcomes for individuals with substance use issues.
- ✓ Implemented an integrated program for severe and persistent mentally ill.
- ✓ Opened 50 longer-term mental health beds.
- ✓ Improved links and supports to address crisis mental health needs.
- ✓ Developed a detailed map of addictions and mental health services across Waterloo Wellington
- ✓ Implemented a suicide intervention program for WWLHIN
- ✓ Increase supports for long-term addictions and mental health conditions to help individuals transition from hospital to community.
- ✓ Implemented a common assessment through the community support coordination team

Improving outcomes for stroke patients through integrated programs

- ✓ Established a regional evaluation and monitoring mechanism to track optimization and best practice stroke care.
- ✓ Developed a plan for system-wide Emergency Medical Services for stroke patients across the WWLHIN.
- ✓ Expanded promotion and public awareness of signs and symptoms of stroke to other models of primary care.

The following activities from the WWLHIN's Integrated Health Service Plan (IHSP) 2010-13 are in progress:

Improving access to, and coordination of, addictions and mental health services

- Implement coordinated intake through the support coordination management team
- Improve the availability of case management and outreach services throughout the WWLHIN
- Support the implementation of local drug strategies across the WWLHIN.
- Support the implementation of the suicide prevention strategy.
- Implement a coordinated approach for addictions and mental health promotion and education in schools.
- Increase primary care capacity to address addictions and mental health issues.
- Improve access to addictions and mental health services for students.
- Implement effective discharge processes and follow up for all addictions and mental health services.
- Implement provincial program called "no wrong door approach."
- Improve transition from crisis services to more stabilized services.

Improving Patient Safety and Enhancing Quality of Care

- Implement resource matching tool to facilitate referral to community services.
- Develop and implemented a Regional Medication Management System in Waterloo Wellington (Pharmacy Optimization Project).

Improving wait times for MRI exams

- Develop and implement guidelines for appropriate use of Magnetic Resonance Imaging (MRI) across the WWLHIN.
- Implement prioritization guidelines and tools for MRI.
- Review all MRI scan protocols (sequencing) and appointment allocation time.

Improving access to primary care

- Develop and implement alternative models for primary care services to address needs for vulnerable populations.
- Support providing information to primary care providers on health issues affecting vulnerable populations.
- Increase awareness around the availability of after-hours care and advanced access.

Decreasing alternate level of care (ALC) days.

- Identify and implement opportunities for LTC homes to optimize use of community resources.
- Refine and consistently apply Long-Term Care (LTC) discharge criteria and policies.
- Develop standardized intake and discharge processes to support specialized care units.
- Launch a 10 bed residential hospice.

Appendix B : Background and Current Status of IHSP 2010-2013 Priorities

IHSP Priority: Improving Patient Safety and Improving Quality of Care

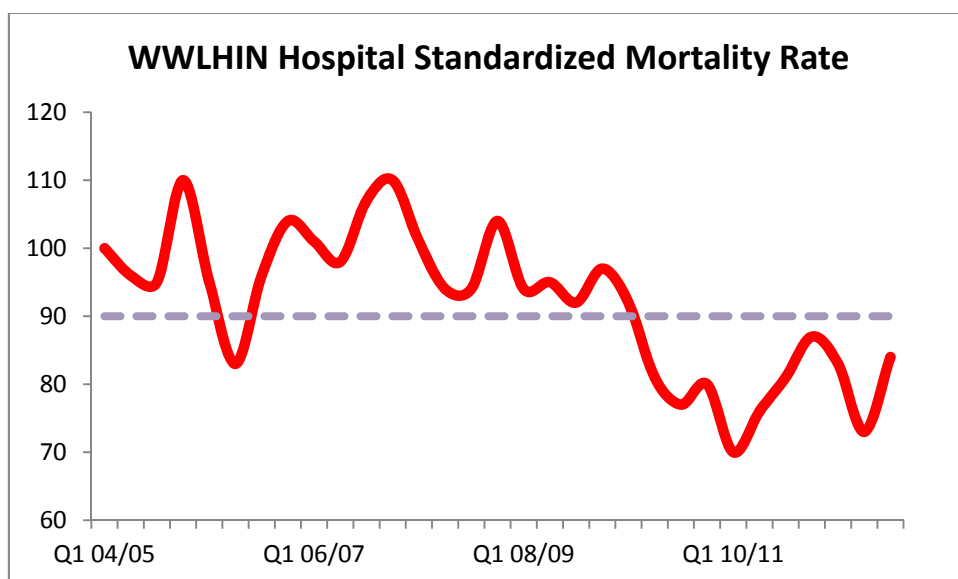
IHSP Priority Description:

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.

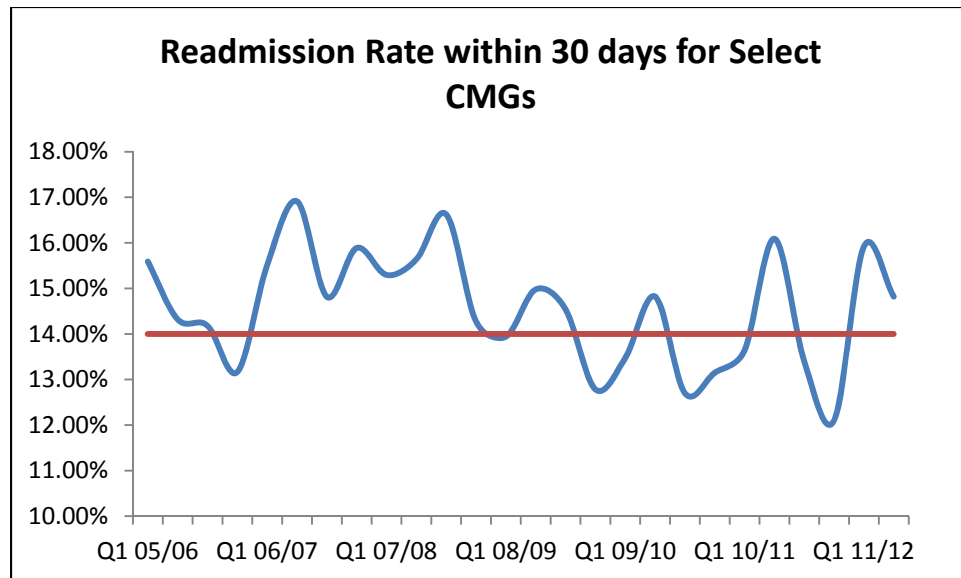
This priority was echoed by the Ontario Health Quality Council (now Health Quality Ontario) who found that Ontarians share a common vision of a high-performing health system and who want a publicly funded health system that is accessible, effective, safe, patient-centred, equitable, efficient, appropriately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

Current Status:

Overall, across the WWLHIN, Hospital Standardized Mortality Rates have been steadily decreasing over the past several years. However, over the last fiscal year (2010/11), we have seen a sharp increase, though we are still under the provincial benchmark of 90. The performance of two local hospitals was recently highlighted locally: St. Mary's General Hospital had an HSMR of 69, which is the fifth lowest number in the country and Grand River Hospitals' HSMR was 78, which represents a five continuous years of improvement. GRH's current score is fourth best out of 14 comparable large community hospitals in the province.



² Ontario Health Quality Council 2009.



Readmission rates continue to fluctuate in WWLHIN, but remain near or below the provincial benchmark. Analysis has shown there has been no discernable pattern that has developed. Downward trends have been noted for certain chronic conditions; however, the movement cannot be attributed to a specific intervention. Rather, this is likely a result of many of the quality initiatives that are underway in Waterloo Wellington, such as:

- GEM nurses in hospital emergency department that are following up with frail individuals
- Easy coordinated access, a central intake and referral system for community support services, which is getting more people connected with supports in the community
- Refresh of Home First across WWLHIN hospital and WWCCAC
- Nurse-led outreach teams that support residents in long-term care homes to reduce emergency department visits and avoidable readmissions to hospital
- Enhanced WWCCAC services
- Increased number of people attached with a primary care provider through Health Care Connect
- Intensive Geriatric Support Workers are working with the frailest seniors in Waterloo Wellington to ensure they are connected with appropriate services to meet their needs.
- Increased coordination of and access to diabetes care as a result of the work of the Diabetes Regional Coordination Centre
- Increases in the numbers of people being referred to the Secondary Stroke Prevention clinic

Further to the programs and services that are aimed at improving quality, enhancing quality and improving patient safety is something that cuts across all the work that is undertaken in the Waterloo Wellington LHIN. 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.

Under ECFAA, the role of Health Quality Ontario expanded to include the following functions: monitor and report to the people of Ontario on several key areas (i.e. Health system outcomes), support continuous quality improvement and to the promote health care that is supported by the best available scientific evidence.

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 April 2011, all hospitals in WWLHIN developed their first Quality Improvement Plans (QIP), as required under ECFAA. These plans were analyzed by Health Quality Ontario in order to determine what learnings could be applied to the next round of submissions by hospitals. The three key messages to learn from this year's submissions are³:

1. Priority setting – the importance of picking the right number of priorities in order to be able to achieve them
2. Target setting – the importance of setting stretch targets (i.e. Aim for theoretical best, or benchmark against a high performing facility elsewhere, 90th percentile among peers, etc)
3. Change ideas – the importance of picking a broad range of change ideas in order to achieve success

³ 2011 Quality Improvement Plan: An Analysis for Learning, Health Quality Ontario (HQP)

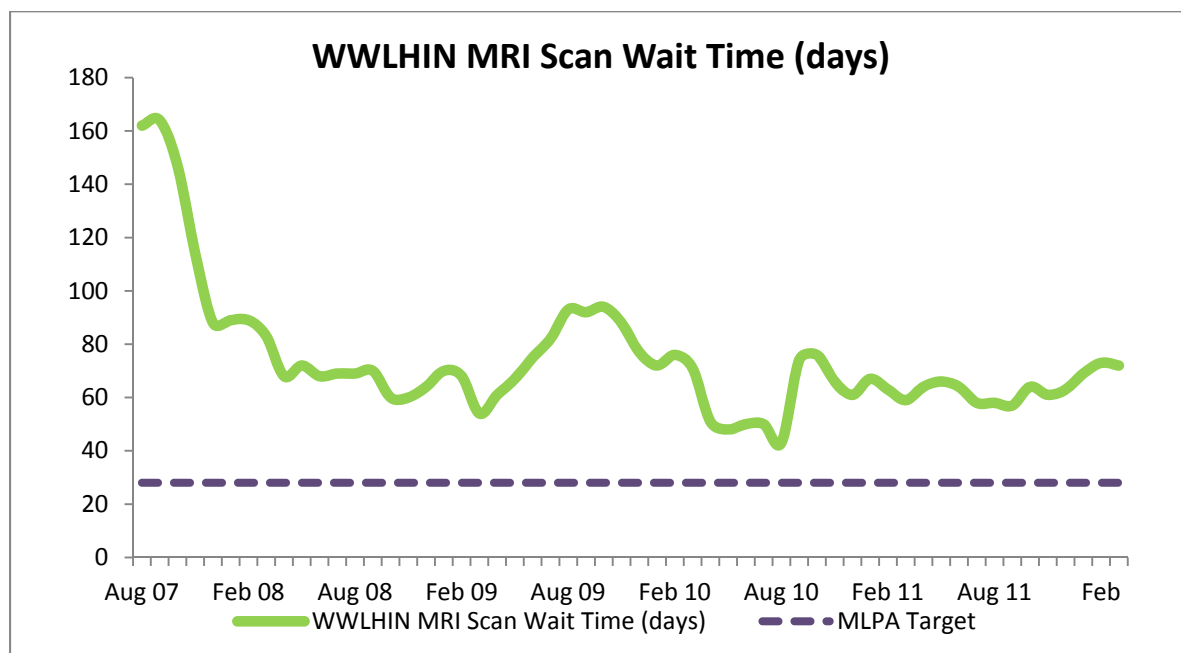
IHSP Priority: Improving Wait Times for Magnetic Resonance Imaging (MRI)

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 64% since wait times were first reported.

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



Current Status:

The MRI/CT working group, through the support and leadership of the WWLHIN, is reviewing how facilities can deliver better quality care by focusing on completing surgeries within the prescribed time for each priority level. Focusing on the different priority levels will lead to best clinical practice. Additionally, a report on sub-specialization and efficiency, created through a better organization of services provided at each hospital, will be completed and implemented in fiscal year 2012/13. The working group has identified that these actions precede the implementation of a central intake process for MRI and other diagnostic exams.

Last year, we reported that in addition to the 2 machines operating at Grand River Hospital (GRH) and Guelph General Hospital (GGH), and the machine privately operated by a community-based clinic, the Ministry of Health and Long-Term Care announced funding for a magnet at Cambridge Memorial Hospital (CMH). This machine began operating in March 2012 and is providing an additional 40 hours per week of scans. CMH's allocation for base service hours is 2080.

Further to uncovering efficiencies in each hospital, in 2011-12 the WWLHIN invested \$2,878,400 in incremental MRI scans and an additional \$23,400 through the Ontario Breast Screening Program (OBSP). The WWLHIN has allocated 57% more volumes for MRI scans in 2011-12 when compared to 2009-10.

IHSP Priority: Improving Access to ED Care

Description:

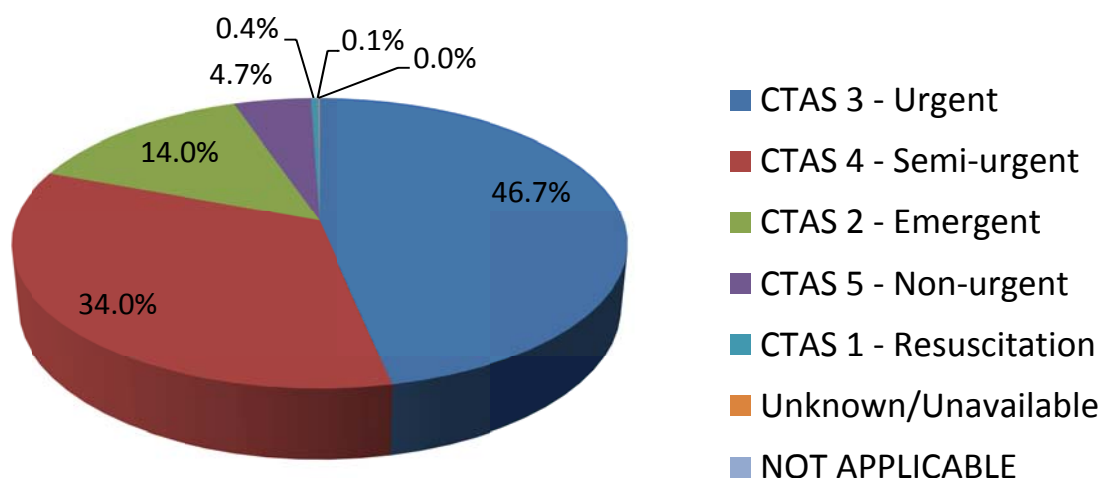
As part of the WWLHIN's commitment to improving patient safety and enhancing quality of care, improving access to emergency department (ED) care has been identified as a priority and a sentinel indicator of overall system quality. This prioritization is consistent with research that demonstrates patients who visit EDs at times when waits are longer are more likely to experience an adverse event, and suggested the best strategy to avoid this risk is to reduce the overall length of stay in EDs for all patients (Guttman et al., 2011).

Current Status:

Six hospital corporations within the WWLHIN boundaries operate Emergency Departments at seven sites. Together, these hospitals provided service for 266,429 ED visits in 2010-2011. Growth in ED volumes has been, for the most part, slow and steady with year-over-year growth rates of 1-2% between 2007 and 2009. However, between 2009 and 2010 WWLHIN experienced a growth in ED volumes of 4.2%.⁴

Understanding both the pressures of a growing community and the risks of overcrowded EDs, the WWLHIN, with health system partners, is dedicated to optimizing appropriate care for patients. One solution the WWLHIN is pursuing, for example, is to the question of whether emergency departments are the appropriate location for caring for the 4.86% of non-urgent ED visits (CTAS 5) and the 37.26% semi-urgent visits (CTAS 4) in Waterloo Wellington (see Improving Access to Primary Care). For those residents who do arrive at a hospital emergency department, we are dedicated to providing people the best care in the most efficient way.

**Percentage of total ED visits by triage level, WWLHIN
FY 2011/12**



⁴ National Ambulatory Care Reporting System, CIHI

Emergency Department sites in Waterloo Wellington have engaged in provincial initiatives designed to improve wait times performance. As shown in the table below, Waterloo Wellington LHIN has committed in its accountability agreement with government to achieve targets for patients requiring admission, complex patients who are not admitted, non-complex patients who are not admitted, and the time to physician initial assessment. These target times measure from the time a person registers or initially see a triage nurse, until the time they leave the hospital or are admitted to an inpatient unit.

	LOS for Admitted Patients Target for 90th Percentile = 20 hours	LOS for Complex Non-Admitted Patients Target for 90th Percentile = 6.8 hours	LOS for Non-Complex, Non-Admitted Patients Target for 90th Percentile = 4.1 hours	Time to Physician Initial Assessment Target for 90th Percentile = 4.05 hours
Starting Point for 2011/12	29.32 hours	7.52 hours	5.12 hours	4.6 hours
WWLHIN Q1 2011/12	28.3 hours	7.6 hours	5.1 hours	4.6 hours
WWLHIN Q2 2011/12	27.9 hours	7.7 hours	4.9 hours	4.6 hours
WWLHIN Q3 2011/12	22.7 hours	7.1 hours	4.4 hours	4.1 hours
WWLHIN Q4 2011/12	24.1 hours	8.0 hours	5.0 hours	5.0 hours
WWLHIN FY 2011/12	26.1 hours	7.6 hours	4.9 hours	4.6 hours

To help achieve the targets, five WWLHIN hospitals have participated in different stages of two provincial programs. The Process Improvement Program (PIP) Wave 1 in 2009 to 2010 dedicated resources to value-stream mapping in EDs. The Pay for Results (P4R) Program has grown from one to four WWLHIN hospitals between 2008-09 and 2011-12 and involves dedicated funds offered to hospitals to fund performance improvements contingent on their achievement of results.

To date, Network performance has shown some important improvements. From the 2008-09 fiscal year to the first six months of the 2011-12 year, the 90th Percentile Wait Time for admitted patients has decreased from 29.2 hours to 27.9 hours. This decrease means that from the 30,000 people who needed to be admitted to hospital through a visit to the ED, the wait time for the 90th percentile patient decreased by 90 minutes compared to four years ago. The equivalent reduction for non-Admitted, Complex Patients was 8.0 hrs to 7.7 hrs (18 minutes) and for non-Admitted, Non-Complex patients was 5.7 hrs to 4.6 hrs (66 minutes).

Analysis at the hospital level shows some variation that reveals more promising results and some enduring challenges. For example, the best performing hospital has achieved further improvements and has maintained performance at the network target for admitted patients (< 20 hours) in the face of substantial annual volume increases. The 90th percentile patient at the worst performing hospital waits 18 hours longer in the ED before being admitted to an inpatient bed.

Recognizing variation between all EDs in the Network, the WWLHIN has identified some key successes from hospitals who have delivered short-term and more sustained improvements in Emergency Department performance. These include:

1. A dedicated improvement or steering committee that includes participation from the senior hospital administration (i.e. Chief Nursing Executive, Chief of Staff, Chief Financial Officer, Chief Executive Officer). Other representatives include Directors from across the Hospital (i.e. Medicine (Hospitalists), ED Chief, Surgery) and membership from Decision Support.
2. A goal for that committee is to develop and test new ideas for delivering better emergency department service. Through debating the appropriateness of a particular improvement initiative, and testing initiatives' efficiency by monitoring key metrics on a monthly basis, the committee will become increasingly aware of the drivers of decreased length of stay.
3. Variations of "Flow Coordinator" and "Admissions Nurse" concepts all work when customized for individual hospitals.
4. "See and Treat" and "Rapid Assessment Zone" type programs are proving effective and the number of operational hours is correlating with improvements in left-without-being-seen and provider initial assessment indicators. When staffing challenges result in inconsistent hours of operation, overall ED performance is negatively affected.
5. Use of electronic patient tracking boards in the ED improves information available to the clinical team and makes real time patient length of stay information highly visible.
6. Infection control pressures and patient isolation results in inpatient capacity issues which, in turn, contributes to challenges in admitting patients from ED.

In encouraging all initiatives to be tested and evaluated and for successful initiatives to be adapted and implemented LHIN-wide, the WWLHIN is meeting regularly with physician and administrative leadership at local hospitals to determine how evaluating new ideas and widening the "bright spots" in Waterloo Wellington can be used key concepts that lead to improved ED wait times.

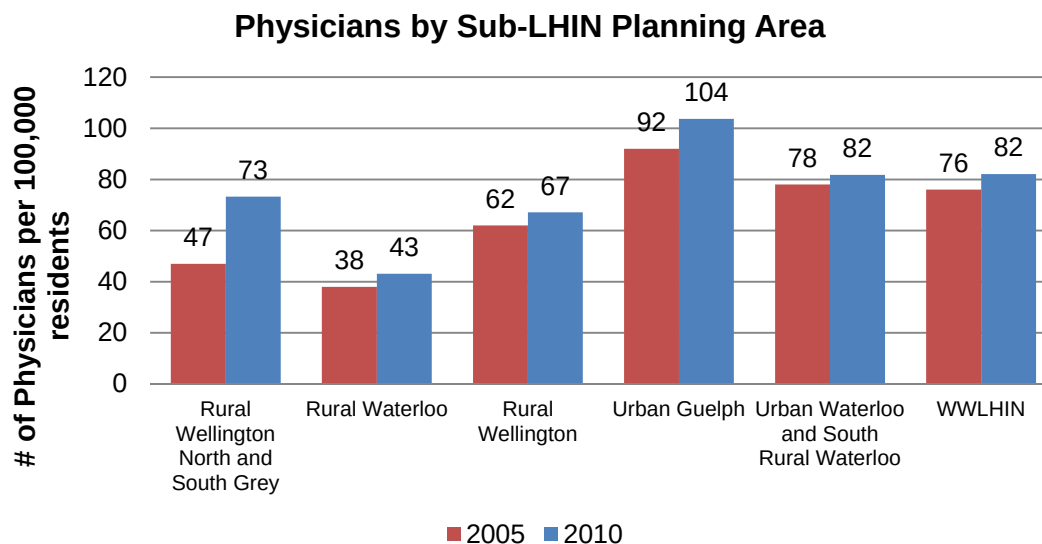
IHSP Priority: Improving Access to Primary Care

IHSP Priority Description:

Primary health providers play an important role in prevention of disease and management and treatment of chronic conditions. Recognizing the role of primary care as fundamental to early identification and intervention for chronic disease, the WWLHIN is committed to ensuring that these services are easily accessible for all residents in Waterloo Wellington and that the primary care sector is integrated with all points on the health care continuum.

Current Status:

According to several sources, approximately 95 per cent of residents in Waterloo Wellington have a primary care physician or place where they go for regular primary care⁵ which is slightly higher than the provincial average of 93 per cent. From a supply perspective, the WWLHIN has approximately 612 physicians (2010) who serve a population of approximately 740,000. This number does not take into account the 100 nurse practitioners that were working in a physician's office or family practice unit in WWLHIN in 2010⁶.

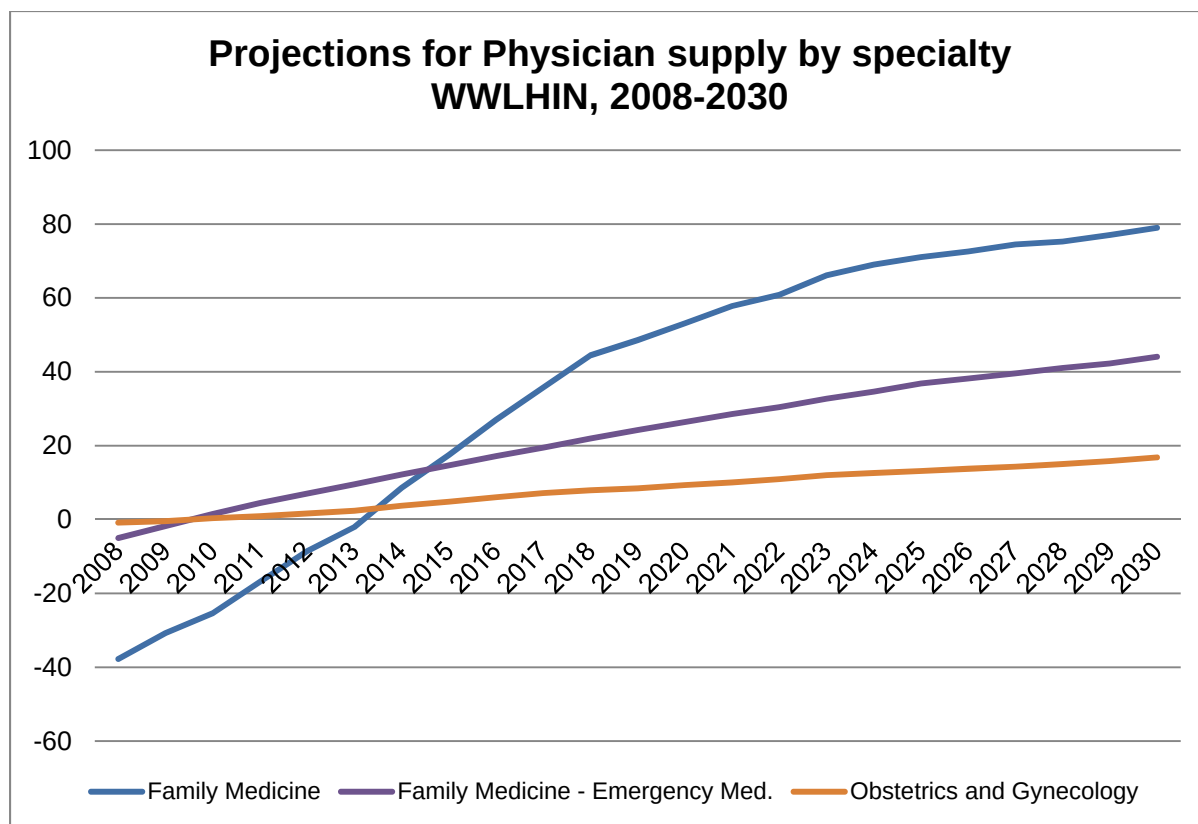


Based on analysis that was done by Health Force Ontario, which looked at current variance in physician supply and demand in the province, Waterloo Wellington has a shortage of 25 family physicians in 2010. This shortage is projected to turn to a surplus by 2014 for family medicine, family medicine/emergency medicine and obstetrics and gynecology.⁷

⁵ MOHLTC Primary Care Access Survey 2008, WWLHIN survey 2010, Statistics Canada, Canadian Community Health Survey.

⁶ College of Nurses of Ontario – Registered Practical Nurses Employed in Waterloo Wellington by Employment Place, 2010

⁷ Ontario Population Needs-Based Physician Simulation Model, October 2010



While physician supply appears adequate, distribution across the WWLHIN is not uniform and many of the challenges that have been present in the past still exist:

- The three rural areas of the WWLHIN, (rural Waterloo Region, rural Wellington, and rural North Wellington and South Grey)⁸ have fewer primary care physicians – access is improving though there are still challenges. However, it is worth noting that the above graph only represents physicians in WWLHIN and we know that many of our rural residents, especially in the northern areas, have a primary care provider that is outside of our boundaries.⁹
- 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 issues¹⁰
- 42% of total emergency department visits were non-urgent (CTAS 4,5) – some of these people could have been more appropriately managed in another setting.¹¹
- Our local Aboriginal community has reported the following challenges with accessing primary care: required medical services were not available in their area, medical services did not meet their cultural needs and lack of access to traditional health care¹².

⁸ Ontario Physician Human Resources Data Centre – Active Physicians in Ontario by Census Subdivision, 2008

⁹ Community Health Care Survey Township of Southgate, Fall 2011

¹⁰ WWLHIN Lesbian Gay Bisexual Transsexual/Transgender Queer (LGBTQ) Online Survey, July 2009

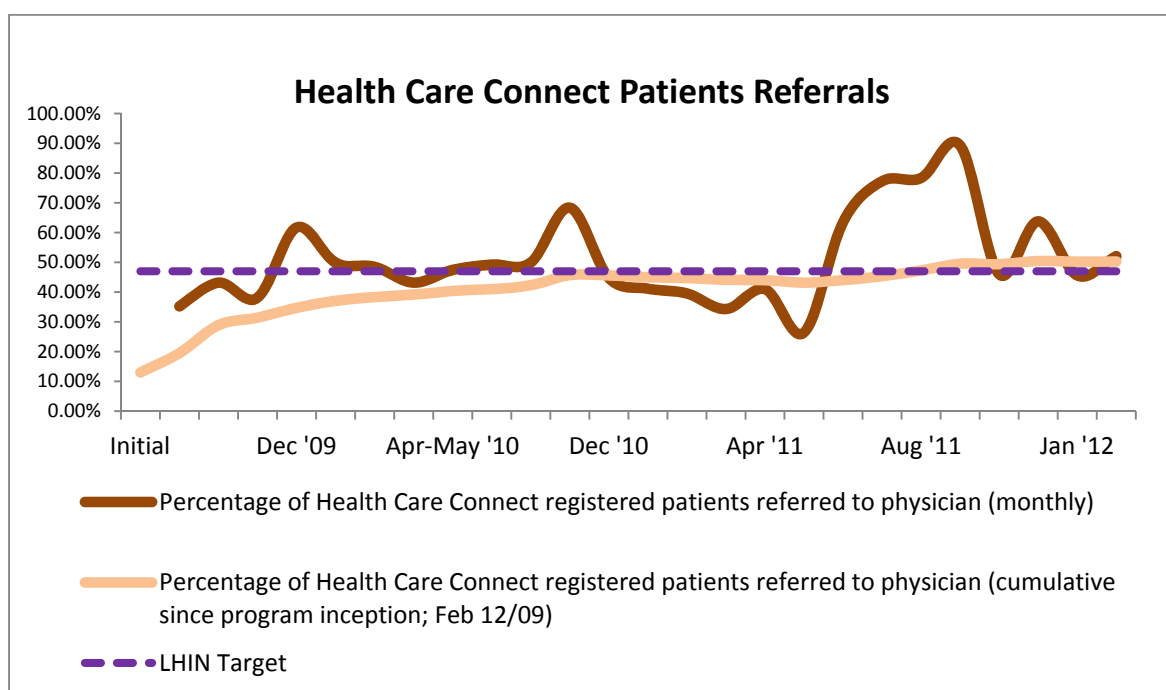
¹¹ Emergency Department Visits, 2009/10

¹² Aboriginal Health Needs Assessment within the Waterloo Wellington Local Health Integration Network, April 2011

There has however, been progress in two key areas:

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 from February 2009 – October 2011 9,450 Waterloo Wellington residents registered with the program. Of those, 4,681 were referred to a primary care provider. Monthly referral rates have experienced a recent increase, which may, be in part, due to the work that has been done to promote the program, specifically in emergency departments and working with the addictions and mental health community to make it less threatening to accept those patients.



- Both Mango Tree Family Health Team (FHT) and the Franklin Medical Clinic are working collaboratively with Health Care Connect to ensure that registered patients will be matched with a primary care provider at their locations.
- A new Family Health Team (FHT) opened in 2011 with sites in Guelph and Kitchener. Mango Tree FHT has 4 doctors and will serve approximately 6,800 people. This FHT will provide services in French and other language as well as English.
- Franklin Medical Clinic opened in Cambridge. They have five doctors and operate a walk-in clinic on weekends. It is estimated to serve approximately 18,000 new patients.
- A new Nurse Practitioner Led Clinic with 2 sites: one in Cambridge (opened in January 2012) and one in the south end of Kitchener (scheduled to open in March 2012).
- An Urgent Care Clinic opened in Guelph that will have four doctors working five days per week.
- Lang's Community Health Centre has opened a new location with a community hub model partnering with a variety of community organizations.
- The Shelldale site of Guelph Community Health Centre has opened in Guelph.

- A new midwifery clinic has opened in Waterloo. With a focus on addressing the needs of vulnerable populations, this clinic has midwives that speak a variety of languages and take patients who have historically had difficulty accessing care.

Integrating the Primary Care Sector:

- A partnership has developed between Guelph General Hospital (GGH) and the Guelph Family Health Team (FHT) to look at patients at the FHT who are going to the ED at GGH. Through examining the data, the Guelph FHT found that their patients accounted for 16,000 ED visits in the year, and that 33 per cent of those visits were non-urgent. Furthermore, 50 per cent of the non-urgent visits occurred during the FHTs operating hours. Having access to this information prompted doctors at both GGH and the Guelph FHT to work collaboratively to explore initiatives that would address some of these challenges.
- A number of physicians in WWLHIN have adopted advanced access procedures in their practice, which has led to shorter wait times for an appointment as well as fewer of their patients going to the ED. The impact of advanced access on ED visits is being further investigated to see if this could be expanded to other areas of the WWLHIN with the same results.
- The Waterloo Wellington LHIN has hired a Primary Care Lead that will act primarily as a champion and strong strategic communicator between the primary care sector and the WWLHIN and will help ensure that resources and capabilities in the primary health care sector are fully utilized.
- Several of our Community Health Centres (CHCs) have been involved in extensive work around addressing the social determinants of health as well as further strengthening their mandate:
 - Guelph CHC conducted a review of priority populations with the goal of ensuring that resources are focused on addressing the needs of the population identified as the CHC's mandate. Guelph CHC is also exploring ways in which they can support the acute care sector in alleviating some pressure in local emergency departments.
 - Woolwich CHC conducted a community needs assessment and has been delivering services that address the social determinants of health, specifically among the Low German speaking population
 - Lang's is in the process of completing their strategic planning cycle and are focusing efforts on addressing the social determinants of health.
 - Kitchener Downtown Community Health Centre has developed the multicultural mental health navigator role to address mental health issues among immigrant populations.

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

IHSP Priority Description:

While improving access to addictions and mental health services is a provincial priority, through data collection and community engagement as part of the IHSP it was also identified as a local priority. Some of the issues of concern locally are: increasing prevalence of both mood and anxiety disorders,¹³ higher rates of substance use among Waterloo Wellington students,¹⁴ a high rate of intentional self harm,¹⁵ and our local Aboriginal community has reported a lack of mental health services, especially for youth¹⁶.

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.

The Waterloo Wellington LHIN currently has 123 publicly funded mental health beds, and an additional 290 privately owned and operated beds that serve privately insured and private pay clients. In 2010-2011, there were approximately 4,460 mental health inpatient separations, that accounted for approximately 123,000 patient days. Three WWLHIN hospitals (Cambridge Memorial Hospital, Grand River Hospital and St. Mary's General Hospital) also provide outpatient care which includes: child/family/seniors mental health services, community outreach, crisis team, medication follow-up and withdrawal management.

Several initiatives are underway aimed at improving access to and coordination of A&MH services:

- Ontario Common Assessment of Need (OCAN) is being implemented in WWLHIN, which is a common assessment for community mental health. The data will be standardized and stored in a common data warehouse (Integrated Assessment Record).
- Mental health and addictions service providers across Waterloo Wellington have been involved in the Support Coordination Review and will be working together to ensure that people have easier access to services and centralized intake and referral.
- Cambridge Memorial Hospital will be opening an interim 22 bed Schedule 1 mental health inpatient unit with outpatient and day programming to support the program. This will allow patients who now travel to London to receive care closer to home.
- The French Mental Health Telemedicine program at Trellis ensures access to psychiatrists for children and adults as well as addictions specialists so that French speaking clients can receive service from a French speaking provider.

¹³ Canadian Community Health Survey 2005, 2007, 2008, 2009

¹⁴ Ontario Student Drug Use and Health Survey, 2007

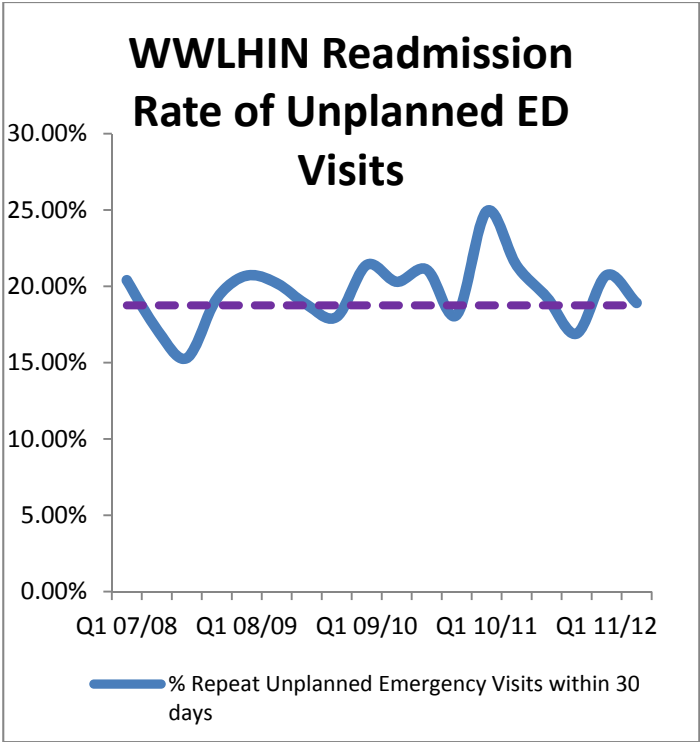
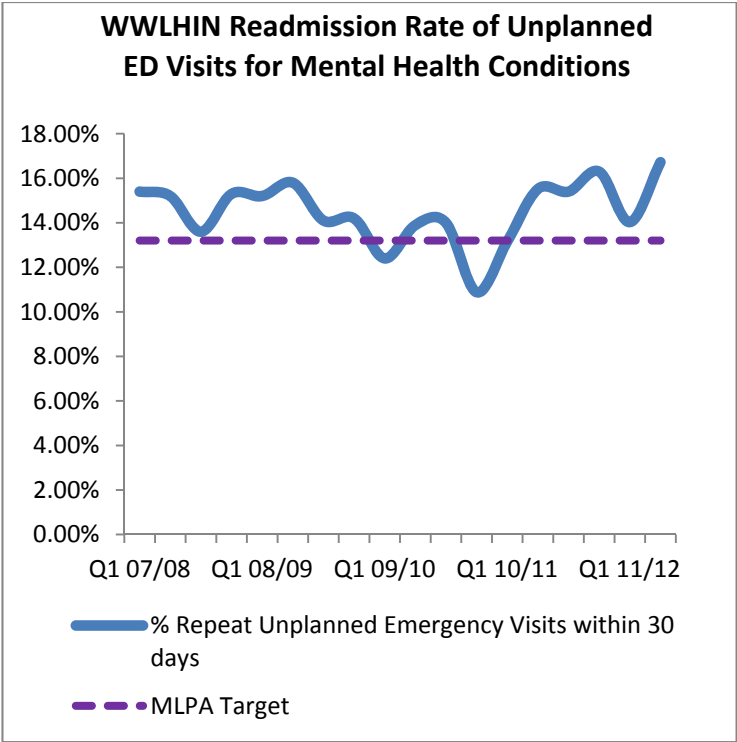
¹⁵ OHQC Quality Monitor Report 2010

¹⁶ Aboriginal Health Needs Assessment within the Waterloo Wellington Local Health Integration Network, April 2011

- Ontario released a comprehensive mental health and addictions strategy which focuses on children and youth in the first three years. Supports focus on three key areas: fast access to high-quality services, early identification and support, and helping vulnerable kids with unique needs. The WWLHIN Integrated Health Service Plan 2010-2013 is aligned with the provincial strategy.
- LHIN Collaborative released a Mental Health and Addictions Working Group Report: Through the Door which offers some practical suggestions to further improve transitions for mental health and addictions clients in each region across the province.
- The Rebound Program targets the primary social and psychological factors that lead youth to engage in substance use and other risk-taking behaviours. It provides young people with up-to-date, accurate information about the effects of various substances and about environmental influences supporting substance use.
- Two Nurse Practitioners have been added to to improve access to eating disorders treatment services, support evidence-based practices in community mental health eating disorders programs, and decrease emergency department wait times.

The Waterloo Wellington Addictions and Mental Health Network is committed to improving access to and coordination of services in Waterloo Wellington. Part of their focus is on reducing emergency department visits for people with addictions and mental health issues. They are working collaboratively with local hospitals to examine frequent ED users to better understand the problem to drive down the repeat ED visits; the following initiatives are having a positive impact on ED visits:

- Addition of 32 addictions supportive housing units and related programming
- The Self Help Alliance and the Canadian Mental Health Association are implementing a best practice suicide intervention program for people who have had multiple suicide attempts and who are experiencing suicidal thoughts. The program contains:
 - 20-week psychosocial psycho-educational group co-facilitated;
 - 4 groups per year with 12 participants – Cambridge (1), Guelph (1) Kitchener-Waterloo (2)
 - Psychiatric and training consultation with group leaders
 - Peer Suicide Intervention groups in each area for those completing the 20-week process
- An evaluation of the outreach program at the Working Centre was completed and showed that the program was helping to reduce ED visits.
- An additional 668 sessional were funded across seven community providers in WWLHIN. The goal of the funding is to strengthen access to community mental health and addictions services for high risk individuals. Funding is to align with the current provincial goals of addressing unattached patients, emergency department congestion and the provincial strategy on mental health and addictions.



IHSP Priority: Improving Chronic Disease Prevention and Management

IHSP Priority Description:

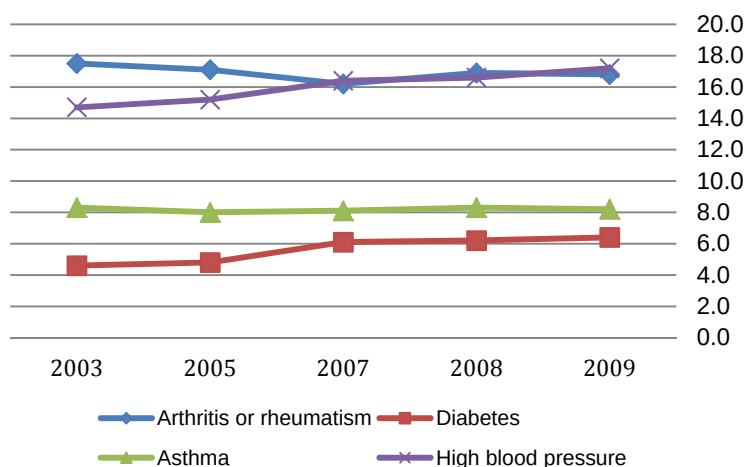
The World Health Organization (WHO) identified chronic disease as a fast growing and serious global issue whose impact on the health of communities and health care economics requires urgent and effective response and action.

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.

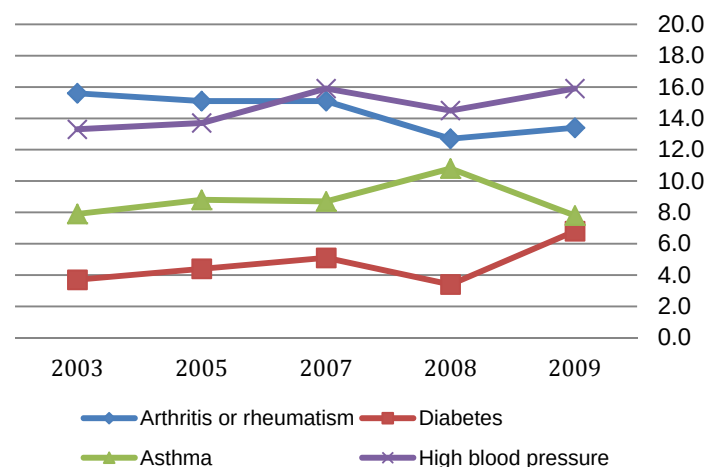
Current Status:

Prevalence rates for diabetes and hypertension have increased between 2003 and 2009 both at the provincial level and locally in Waterloo Wellington. Of particular concern is the amount that these rates have increased between 2003 and 2009 in the WWLHIN (83% for diabetes and 20% for hypertension) compared to the province (40% for diabetes and 17% for hypertension)¹⁷. Disparities in disease rates among cultural groups also need to be addressed. For example, rates of diabetes, asthma, hypertension and arthritis are higher for Aboriginal residents in WWLHIN compared to the total WWLHIN population; in some cases, the rates are almost twice as high¹⁸. Likewise, the percentage of Francophones in Waterloo Region who reported that they drink alcohol regularly is higher than that of the total WWLHIN population¹⁹.

**Chronic Disease Prevalence in Ontario
(2003-2009)**



**Chronic Disease Prevalence in WWLHIN
(2003-2009)**



¹⁷ Canadian Community Health Survey, 2003- 2009

¹⁸ Aboriginal Health Needs Assessment within the Waterloo Wellington Local Health Integration Network, April 2011

¹⁹ Demographic and Health Profile of Francophones in Waterloo, Alliances des Reseaux Ontariens de Sante en Francais (AROSF)

While the percentage of people with diabetes who received all of the appropriate tests within the recommended guidelines has improved slightly from 2009 (43.9%) to 2010 (44.1%); this still means that approximately 56 per cent of people with diabetes are not getting the required tests that are important in managing their symptoms²⁰. This is likely due to the fact that only 19 per cent of people with diabetes in WWLHIN are attending a diabetes education program¹⁵. There were 1,245 ED visits related to diabetes in 2010-11, and 86 per cent of them were urgent²¹.

Diabetes

Planning and design of the diabetes system of care is driven by the work that the Diabetes Regional Coordination Centre (RCC) is doing in Waterloo Wellington. The RCC, established in 2010, under the Ontario Diabetes Strategy (ODS) of the Ministry of Health and Long-Term Care (MOHLTC) is mandated to organize and coordinate diabetes care in the region to ensure that all people with diabetes have access to quality care. The RCC does not provide direct patient services, but works closely with the WWLHIN and service providers to identify and address processes and systems that will enhance the delivery of care for people and families living with diabetes.

Some of the Successes of the Past Year Include:

- Completion of an environmental scan of diabetes services offered in the WWLHIN. Diabetes Programs, Primary Care Providers, Foot Care Specialists, Pharmacists, Dentists, Optometrists/Ophthalmologists and Patients were surveyed to identify services and gaps in care.
- Development of a continuing education conference for health care professionals involved in diabetes care to promote best practices.
- Expansion of the self-management program coordination by organizing existing programs and enhancing the knowledge of health care providers through self-management support activities
- Implementation of a new central intake process for diabetes education referrals utilizing a common referral form. This process improved navigation of the system and access to services.
- Establishment of standard wait times for diabetes services. These wait times will be monitored along with clinical indicators to improve care pathways and patient outcomes.
- Development of patient pathway for gestational diabetes in collaboration with the North-Wellington Health Care Alliance.
- Development of a website for health care providers and patients to be able to properly navigate the system and access resources - partnered with the Canadian Diabetes Association to produce and distribute the Directory of Services.

²⁰ Baseline Diabetes Dataset Indicators report 2010

²¹ National Ambulatory Care Reporting System, 2010

Recognizing the role that the social determinants of health play in health status, the WWLHIN and the RCC have been working collaboratively with health service providers to ensure that programs are addressing the social determinants of health. Some examples of this work include:

- Providing a comprehensive framework for providing and developing outreach services to reach at risk populations. The focus is on addressing health literacy and the social determinants of health.

Chronic Kidney Disease

Our Regional Renal Program works closely with the diabetes RCC and is located at Grand River Hospital. It provides high quality care at the KW site and Freeport site, as well as two satellite sites; one located in Guelph and one in Palmerston. The focus over the past year has been to increase independent dialysis rates, which means that people are able to dialyze at home rather than having to go to a hospital location several times a week. As well, the program aims to increase the fistula use rate as the vascular access option. This is the preferred method to decrease the infection and complication rates are lower. Rates of home hemodialysis in WWLHIN have grown at approximately 10 additional patients per year over the last three years. While our fistula rates have remained relatively unchanged at approximately 32 per cent, the program has implemented several initiatives to help grow this number.

The following initiatives are underway in Waterloo Wellington and are aligned with local health system priorities as well as the direction of the Ontario Renal Network (ORN):

- The Regional CKD program is examining emergency department data to understand which patients are going to the ED several times and are developing initiatives to follow up with patients after a visit to ensure that their care needs have been met with the goal of averting a subsequent ED visit.
- The Regional program is working jointly with the WWLHIN, ORN and MOHLTC to update the application process for long-term care homes to provide peritoneal dialysis care to residents.
- Through funding from ORN the Regional Program has been able to hire a Vascular Access Coordinator and an Independent Dialysis Navigator with the goal of improving the rates in these two areas.

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 2009 - 2010, the age and sex-adjusted rate of stroke/TIA (transient ischemic attack) patients arriving in emergency departments in the WWLHIN was 1.9 per 1,000 population, which was the same as the provincial average. This translated into 1,596 Emergency Department (ED) visits due to stroke. Across Waterloo Wellington an EMS stroke redirect system sends stroke patients to our designated stroke centre, which is Grand River Hospital (GRH) so they can receive thrombolysis treatment. The treatment, if given within 4.5 hours of symptom onset, can reduce the damage associated with a stroke. Because of this redirect system Grand River Hospital saw the most patients (44%) with smaller numbers going to Guelph General, Cambridge Memorial, St. Mary's General, Groves Memorial and the two North Wellington sites.

The time frame in which it is safe to deliver the life saving thrombolysis (tPA) treatment increased from 3 hours to 4.5 hours. In 2008/09 GRH administered tPA to 30 people and in 2009/10 49 people were appropriately administered tPA; which can reduce the damage and deficits of ischemic stroke

Grand River Hospital has a 13 bed stroke unit that treated 50 per cent of all stroke patients in Waterloo Wellington. People seen at a designated unit have better outcomes (reduced mortality rates and readmission rates) than people treated on a general unit however; 50 per cent of stroke patients in WWLHIN are not benefitting from being treated at a designated site. The Central South Regional Stroke Network has set a target of 80 per cent admission of stroke patients by the end of 2012. Waterloo Wellington continues to have sub-optimal performance in many dimensions of stroke care as illustrated in the Ontario Stroke Network Annual Report Card below.

²² Waterloo Wellington Stroke Review, 2010

Recognizing these areas for improvement, several health service providers have come together across the WWLHIN with a commitment to implementing an integrated stroke program, where every stroke patient would be treated on a designated stroke unit with specialized staff to walk them through their journey to recovery. There have been several accomplishments in this area:

- A model for an integrated stroke program in WWLHIN has been locally developed
- It has been recommended that all stroke care in WWLHIN will be provided in a “banding model”. The band a patient is placed in is determined by the results of their evidence-based assessment.
- It has been recommended that all acute stroke patients be treated at Grand River Hospital KW Site, the District Stroke Centre, and that rehabilitation care for stroke patients be provided at 2 sites in WWLHIN: Grand River Hospital Freeport Site and St. Joseph’s Health Care Centre, Guelph. Health service providers are working together to begin implementing the model across Waterloo Wellington.
- The linking survivors with survivors program continues to offer support to people recovering from a stroke with positive outcomes.
- Guelph General Hospital has co-located stroke patients at their facility and these patients are being treated by staff trained specifically in stroke care. Since the cohorting of these patients the hospital has realized significant efficiencies and has reduced the number of beds required to treat stroke patients.

Ontario Stroke Report Card: Local Health Integration Network Report FY10-11
LHIN: Waterloo Wellington (3)

Poor performance ¹
Acceptable performance ²
Exemplary performance ³
Benchmark not available ⁴

Indicator No.	Care Continuum Category	Indicator ⁵	LHIN FY 10-11 (FY 09-10)	Variance within LHIN (min - max)	Provincial Benchmark ⁶	High Performer	
						Facility/SubLHIN	LHIN
1	Public Awareness and Patient Education	Proportion of patients who arrived at ED less than 3.5 hours from stroke symptom onset.	44.5% (32.9%)	28.3 - 49.7%	52.0%	Elgin	2, 11
2	Prevention of Stroke	Annual age- and sex-adjusted inpatient admission rate for stroke/TIA (per 1,000	1.4 (1.4)	1.2 - 1.7	1.1	Northwest Mississauga	0
3	Prevention of Stroke	Risk-adjusted stroke/TIA mortality rate at 30 days (per 100 patients).	15.4 (12.9)	9.8 - 27.5	14.3	Lakeridge Health -	7
4	Prevention of Stroke	Proportion of ischemic stroke/TIA patients with atrial fibrillation prescribed or recommended anticoagulant therapy on discharge from acute care.	63.6% (80.3%)	55.4 - 100.0%	86.0%	Queensway-Carleton Hospital	0
5	Prevention of Stroke	Proportion of ischemic stroke patients without atrial fibrillation who received carotid imaging prior to hospital discharge.	83.0% (74.9%)	33.3 - 100.0%	92.8%	Markham Stouffville Hospital	5
6	Acute Stroke Management	Proportion of suspected stroke/TIA patients who received a brain CT/MRI within 24 hours of arrival at ED.	90.8% (90.1%)	0.0 - 100.0%	97.7%	Cambridge Memorial Hospital	5, 7
7	Acute Stroke Management	Proportion of ischemic stroke patients who arrived at ED less than 3.5 hours from symptom onset and received acute thrombolytic therapy (tPA) (excluding those with	25.4% (23.5%)	0.0 - 39.8%	61.2%	Trillium Health Centre	0
*8	ACUTE STROKE MANAGEMENT	PROPORTION OF STROKE/TIA PATIENTS TREATED ON A STROKE UNIT AT ANY TIME DURING THEIR INPATIENT STAY.	43.9% (30.2%)	0.0 - 79.1%	87.5%	North Bay General Hospital	0
9	Acute Stroke Management	Proportion of stroke (excluding TIA) patients with a documented initial dysphagia screening performed during admission to acute care.	67.7% (56.7%)	0.0 - 81.9%	83.7%	Thunder Bay Regional Hlth Sciences Centre	14
10	Acute Stroke Management	Proportion of ALC days to total length of stay in acute care.	36.9% (n/a)	14.5 - 64.6%	14.0%	Halton Healthcare Services - Oakville	2
*11	ACUTE STROKE MANAGEMENT	PROPORTION OF ACUTE STROKE (excluding TIA) PATIENTS DISCHARGED FROM ACUTE CARE AND ADMITTED TO INPATIENT REHABILITATION.	29.4% (29.5%)	20.5 - 34.3%	42.3%	Chatham-Kent	1
12	Stroke Rehabilitation	Proportion of stroke (excluding TIA) patients discharged from acute care who received a referral for outpatient rehabilitation.	4.9% (5.2%)	0.0 - 7.9%	12.1%	Burlington	14, 13
13	Stroke Rehabilitation	Median number of days between stroke (excluding TIA) onset and admission to stroke inpatient rehabilitation (RCG-1 and RCG-2).	11.0 (11.0)	9.0 - 11.0	7.0	Grey Bruce HS-Owen Sound	9
14	Stroke Rehabilitation	Rehabilitation therapy staff/bed ratio for inpatient stroke rehabilitation.	--	--	--	--	--
15	Stroke Rehabilitation	Proportion of ALC days to total length of stay in inpatient rehabilitation (Active+ALC) (RCG-1).	14.4 (n/a)	4.9 - 17.9%	6.3%	Trillium Health Centre	6
16	Stroke Rehabilitation	Median FIM Efficiency for moderate stroke in inpatient rehabilitation (RCG-1).	0.8 (0.7)	0.6 - 0.9	1.1	Royal Victoria Hospital	9
17	Stroke Rehabilitation	Mean number of CCAC visits provided to stroke/TIA patients in 2008/09 and 2009/10.	6.9 (7.0)	n/a	6.8	n/a	5, 3
18	Stroke Rehabilitation	Proportion of patients admitted to inpatient rehabilitation with severe strokes (RPG= 1100 or 1110) (RCG-1).	27.4% (25.5%)	21.9 - 28.8%	46.9%	Royal Victoria Hospital	0
19	Re-integration	Proportion of stroke/TIA patients discharged from acute care to LTC/CCC (excluding patients originating from LTC/CCC).	13.0% (13.9%)	8.6 - 15.4%	4.7%	Manitoulin-Sudbury	13
*20	RE-INTEGRATION	AGE- AND SEX-ADJUSTED READMISSION RATE AT 30 DAYS FOR PATIENTS WITH STROKE/TIA FOR ALL DIAGNOSES (per 100 patients).	6.6 (7.3)	0.0 - 10.9	8.0	Kingston General Hospital	10

¹ Poor Performance = Below 50th percentile

² Acceptable Performance = At or above 50th percentile and > 5% absolute/relative difference from benchmark

³ Exemplary Performance = Benchmark achieved or within 5% absolute/relative difference from benchmark

⁴ Data not available or benchmark under development

⁵ Facility based analysis (excluding indicators 1, 2, 11, 12 and 19) for patients aged 18 to 108. Indicators 1, 4 - 9, 12 are based on FY1011 (FY0809 displayed in brackets) OSA data otherwise CIHI databases.

(Low rates are desired for indicators # 2, 3, 10, 13, 15, 19 and 20.)

⁶ Provincial benchmarks were calculated using the ABC methodology, except for indicators 3, 15 and 20 where the provincial rate was used. For benchmarking methodology, see Weissman et al. J Eval Clin Pract. 1999; 5(3):269-81.

⁷ High performing acute sites include high volume institutes (those that treat more than 100 strokes per year) and high performing rehab sites include sites with moderate volumes (those that admit more than 42 stroke patients per year).

* Hospital Service Accountability Agreement indicators, 2010/11

-- data not available

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

IHSP Priority Description:

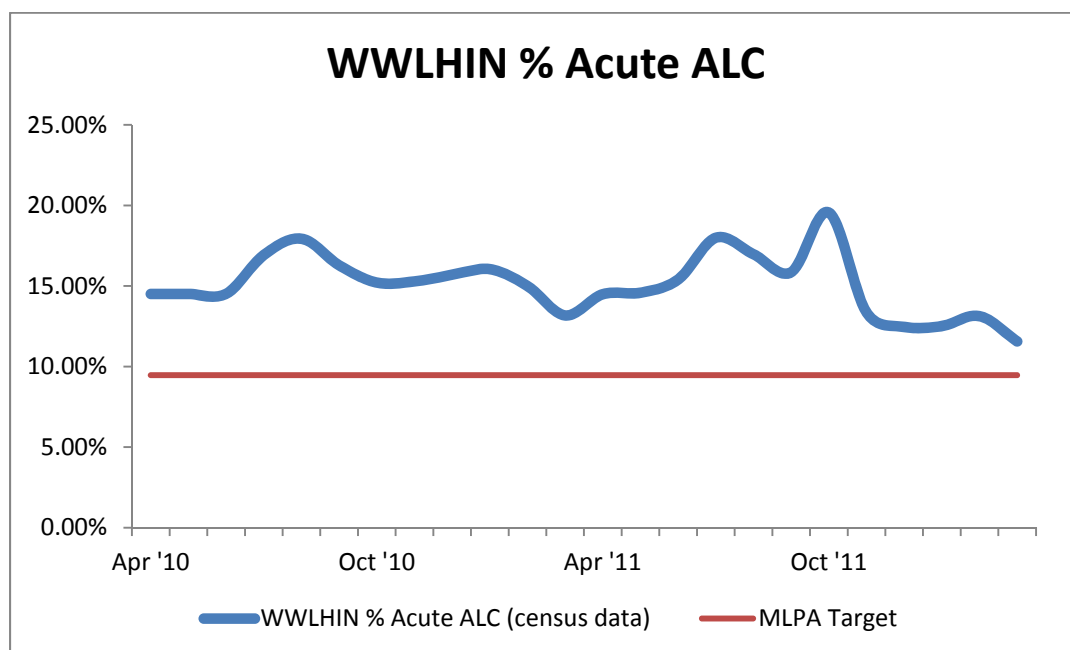
Every year in Waterloo Wellington, 220,000 people come to an Emergency Department, 49,000 of which will go on to be admitted to an acute care bed. In addition, 24,000 people are admitted each year to a hospital in Waterloo Wellington for elective care. Of those who are admitted to an acute care inpatient bed, 3,000 will stay in that bed longer than their care needs require. We refer to days spent in an acute care bed where patient care needs could have been better met in an alternative level of care as Alternate Level of Care (ALC) Days.

Approximately 100 beds in Waterloo Wellington hospitals are occupied by ALC patients on any given day. While seniors account for 50% of all acute care hospital days, they often face the most challenge when trying to get home again and account for 87% of all ALC days.

When beds are occupied by patients who require an alternate level of care, available capacity for new patients arriving through the emergency department or waiting for surgeries is reduced, thus putting further pressure on wait times. Of the 100 acute care beds that are ALC in Waterloo Wellington on any given day approximately 75 of those beds are on a medical unit and 24 beds are on a surgical unit, effectively reducing the acute care capacity of the local system by 20% for medicine and 11% for surgery.

Current Status:

Progress is being made despite that fact that ALC has been a challenging problem in all geographies, including Waterloo Wellington. Both the WWLHIN and provincial ALC rates are trending down and the gap between our performance in Waterloo Wellington and the Provincial performance has closed.



In developing our strategy, we spent time as a WWLHIN team to understand what the data was telling us and engaging in discussions with our partners across the system. We also identified leading practices and listened to experts such as Dr. David Walker.

Data indicates that 10% of people account for 50% of the ALC days; therefore we need to focus our strategy on the specific needs of individuals. We also know that the elderly experience physical decline while in hospital and activation for seniors is one way to prevent further decline and change the destination for people leaving hospital. History also clearly shows that just creating more system capacity alone, particularly in Long-Term Care Homes, will not alleviate ALC; however, targeted investments are still needed where there are gaps. Through problem solving with system partners, we have developed an ALC strategy that applies this learning in a comprehensive package of change:

- Home First – a philosophy of care that recognizes that home is the best place to make life altering decisions like deciding to move to LTC
- Targeted Investments aimed at preventing people from unnecessarily becoming ALC:
 - Hospital Elder Life Program (H.E.L.P) – a program which provides care to the frail elderly to help avoid serious complications of hospitalization
 - Longer-Term Ventilator Weaning
- Targeted Investments that focus on providing services in the community for patients who once they become ALC tend to have a very long hospital stay:
 - Community supports for complex mental health needs
 - Community supports for palliative care
- Restorative Care enhancements including additional therapy resources and streamlined admission criteria and processes.

Since September 2011, hospitals and the WWCCAC have been “refreshing” their approach to Home First and there are promising early indications of success. Two hospitals in particular, Cambridge Memorial Hospital and St. Mary's General Hospital, in partnership with the WWCCAC have demonstrated a significant success in helping people to get home again after a hospital stay.

