Waterloo Wellington **LHIN**

ANNUAL BUSINESS PLAN 2015-16

Ontario
Local Health Integration Network

OUR **MISSION** IS:
To lead a high-quality integrated health system for our **residents**.

OUR **VISION** IS:
Better Health – Better **Futures**.

OUR **CORE VALUE** IS:
Acting in the **best** interest of our **residents'** health and well-being.

TABLE OF CONTENTS

Our RESIDENTS and FAMILIES are at the heart of our strategy to improve access, service and quality within our local health care system.

WATERLOO WELLINGTON LOCAL HEALTH INTEGRATION NETWORK

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

Vision: Better Health – Better Futures.

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

The Waterloo Wellington Local Health Integration Network (Waterloo Wellington LHIN) is responsible for planning, integrating (connecting and improving) and funding health services to improve the health and well-being of approximately 775,000 residents in Waterloo Region, Wellington County, the City of Guelph and the southern part of Grey County.

We work with local residents and health care providers to identify and meet the unique health needs of our community. The Waterloo Wellington LHIN team is comprised of doctors, nurses and other health care and business professionals who are dedicated to providing a resident-focused approach to local health care funding, design and improvement.

One of the greatest benefits of having a Local Health Integration Network (LHIN) is that we're part of the community we serve. Because we're local, we can bring people from across our community together to support the work that needs to be done to transform the system into a fully coordinated one and to address the root causes of poor health in Waterloo Wellington.

Most importantly, we interact with local residents, health service providers and community leaders each and every day. Their perspectives help us understand the unique needs and challenges in each of our communities. As we work to build a robust community of professionals dedicated to improving the health of Waterloo Wellington residents, we also support health service providers in the work they do to improve health services and patient care. When necessary, we intervene in decision making processes to ensure that the decisions that are made are in the best interest of residents.

The Annual Business Plan was built based on the needs and ideas of our residents and health service providers. It's not our plan – it's the health care system's plan – and through partnership with our health service providers, residents and community leaders, we will deliver on it to improve the health and well-being everyone in Waterloo Wellington.

THE PLAN FOR HEALTH SYSTEM TRANSFORMATION

The current health care system includes all of the organizations, programs, services and people, who work to provide our residents with health care. This includes everything from hospitals, family doctors, nurses and home care workers, to meals on wheels, long-term care, diabetes education and more. As you can tell, it is a very big and diverse group – there are many people in the system working together to make it better.

THE PROVINCIAL VISION

In 2012, the Ontario Government launched an "Action Plan for Health Care" to build a quality health care system for Ontarians that is more responsive to patient needs and delivers better value for taxpayers. Its three priorities included: keeping Ontario healthy, faster access to stronger family health care and providing the right care, at the right time, in the right place. In 2015, the province introduced the next phase of transformation of the health care system. Patients First: Ontario's Action Plan for Health Care sets out four key policy pillars that will have a significant impact on our work in the coming year and beyond. Those pillars are:

- Improve Access – provide faster access to the right care
- Connect services – deliver better coordinated and integrated care in the community, closer to home
- Support people and patients – provide the education, information and transparency they need to make the right decisions about their health
- Protect our universal public health care system – make decisions based on value and quality, to sustain the system for generations to come.

PUTTING PATIENTS FIRST MEANS:

- Supporting Ontarians to make healthier choices and help prevent disease and illness.
- Engaging Ontarians on health care, so we fully understand their needs and concerns.
- Focusing on people, not just their illness.
- Providing care that is coordinated and integrated, so a patient can get the right care from the right providers.
- Helping patients understand how the system works, so they can find the care they need when and where they need it.
- Making decisions that are informed by patients, so they play a major role in affecting system change.
- Being more transparent in health care, so Ontarians can make informed choices.

THE REGIONAL SYSTEM VIEW

The Waterloo Wellington LHIN works within the provincial context to deliver meaningful change at the local level. We take the province's vision and then consider the unique health needs of our diverse population, especially those at highest risk for poor health, and work with our health service providers and

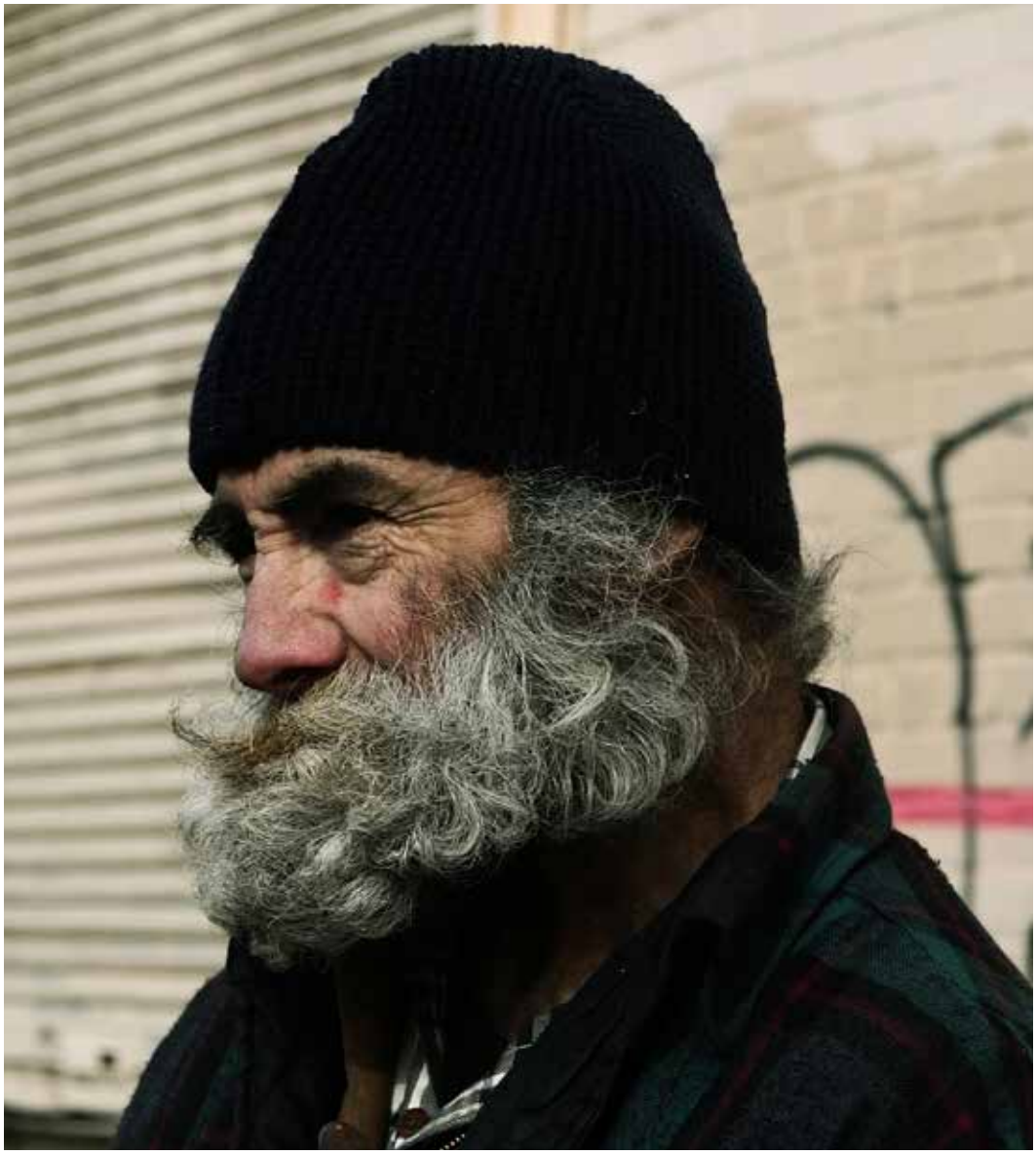
community leaders to address the root causes of these situations and identify where the pieces of the health system need to be better connected.

The following pages of the Annual Business Plan (ABP) summarize the initiatives that the health system will undertake to achieve the results outlined in the Integrated Health Service Plan (IHSP) in each of three priority areas:

- Enhance access to primary care
- Create a more seamless and coordinated health care experience
- Lead a quality health care system using evidence-based best practice

Progress on each of these initiatives is led and closely monitored at specific council or network tables as well as at individual health service provider levels. The LHIN also produces a summary dashboard based on our reporting obligations to our Board, community and government.

This information is communicated regularly at our Board of Directors meetings, posted to our website and also reviewed at network and council meetings.

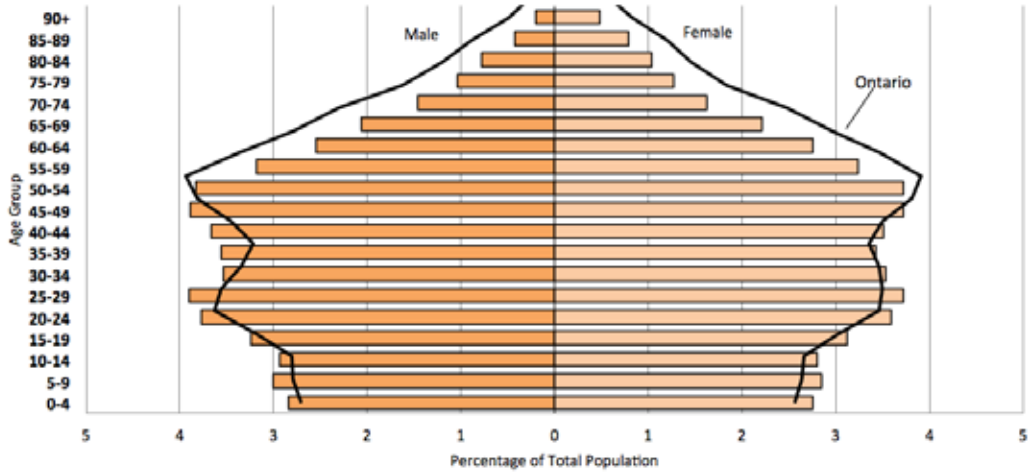


THE LOCAL CONTEXT: ENVIRONMENTAL SCAN

POPULATION SNAPSHOT

The Waterloo Wellington LHIN is home to over 775,000 residents, 5.7% of the population on Ontario. Waterloo Wellington's population is projected to grow by 32.1%, or over approximately 230,000, over the next 28 years from an estimated 775,000 residents to over 1 million residents by 2041. Our population continues to grow at a rate of about 1.1% each year, which is slightly faster than the province as a whole. Roughly 80,000 residents live in rural areas (11% of the population). The majority of rural residents live in the Rural Wellington region. The Waterloo Wellington LHIN has a relatively young population with 86% of residents under the age of 65 years (See Chart 1 for Population Pyramid comparing Waterloo Wellington to the Province) and 24% under 20 years. There are approximately 110,000 Waterloo Wellington residents who are over the age of 65 years.

Chart 1: Age-Sex Population Distribution, Waterloo Wellington, 2013



Source: IntelliHealth Ontario Population Projections, Ministry of Finance (based on 2006 Census). Last updated September, 2013.

Between 2012/13 and 2013/14, the Region of Waterloo (home to approximately 530,000 residents) experienced the greatest population growth in Waterloo Wellington LHIN with over 5,000 new residents to the region. Natural growth accounts for 57% of this increase, while net migration accounts for 43%; international migration accounts for the majority of this increase as inter-provincial migration is almost net zero.

There are approximately 12,005 residents who include French as their mother tongue, or whose mother tongue is neither French nor English but have a particular knowledge of French as an Official Language and use French at home.

WWLHIN's TOTAL POPULATION
778,676

RURAL AREA POPULATION
11%

SENIORS (65 YEARS & OLDER)
14.3%

IMMIGRANT POPULATION
20.6%

ABORIGINAL POPULATION
1.4%

SOCIO-DEMOGRAPHIC PROFILE:

Table1: Socio-demographic Profile of Waterloo Wellington LHIN residents by region of residence

	Immigrant Population		Aboriginal Identity		Unemployed		Spending 30% or more of household total income on shelter costs		In low income in 2010		Education - No high school certificate diploma or degree	
	Count	%*	Count	%*	Count	%**	Count	%***	Count	%*	Count	%****
Waterloo Region	111,495	22.3%	6,825	1.4%	19,865	7.0%	45,365	23.8%	59,220	11.9%	82,010	20.2%
Wellington County	34,375	16.7%	3,200	1.6%	7,170	6.1%	18,495	24.0%	21,780	10.6%	33,155	19.7%
WWLHIN	146,570	20.5%	10,180	1.4%	27,315	6.7%	64,440	23.9%	82,100	11.5%	116,845	20.1%
Ontario	3,611,365	28.5%	301,430	2.4%	567,985	8.3%	1,303,190	27.0%	1,745,900	13.8%	1,954,520	18.7%

*Percent of population in private households

** Percent of population over 15 years

***Percent of Total number of owner and tenant households with household total income greater than zero, in non-farm, non-reserve private dwellings

**** Percent of Total population aged 15 years and over by highest certificate; diploma or degree

Over 20% of the population of Waterloo Wellington are immigrants, while almost 12% are visible minorities; these population proportions are lower than what is experienced Provincially. In Waterloo Region immigrants account for 22% of the total population (over 111,000 residents), while in the Wellington County region immigrants account for less than 20% of the population (almost 35,000 residents).

There are over 10,000 Aboriginal peoples in the Waterloo Wellington LHIN representing 1.4% of our total population. The majority of Aboriginal residents live in Waterloo Region (67%) and Wellington County (31%). Aboriginal residents in Waterloo Wellington LHIN have lower education and income levels, and higher unemployment rates compared to the rest of the LHIN. Additionally, estimated rates of asthma, diabetes and chronic bronchitis are about twice as high for Aboriginal residents compared to the total population in the LHIN.

Waterloo Wellington residents experience a low unemployment rate (6.7%) compared to other LHINs (Provincial unemployment rate: 8.3%). The unemployment rate in Waterloo Region is higher than in Wellington County, 7.0% and 6.1% respectively. There are 2.8 times as many unemployed residents living in Wellington Region compared to Wellington County (19,860 vs 7,170). Approximately 58% of residents have completed post-secondary training, with a highest attainment in the Guelph region (62.4%) and the lowest in Rural wellington (52%). There are over 80,000 residents in Waterloo Wellington who are living below the low-income cut-off.

The average life expectancy for Waterloo Wellington LHIN residents is 82 years of age. The death rate from avoidable deaths (those that might be avoided through prevention: vaccination, lifestyle changes and injury prevention) has been decreasing in Waterloo Wellington and is lower than the Provincial and National death rates.

[1]Waterloo Wellington LHIN contains Waterloo Region, Wellington County and a small portion of Grey County (approximately 8,000 people)

Poor health practices are correlated with increased risk of chronic conditions, disability and death. Roughly 17% of residents are daily smokers, while over half of the adult population is overweight or obese and almost 60% of residents report they consume less than five servings of fruits and vegetables daily.

KEY DRIVERS

Over the last two years, through programs such as Healthcare Connect and Health Links we have been very successful in connecting more people in our region with a Primary Care Provider. There has been an increase in the number of primary care providers in the region, including those whose practice is dedicated to caring for residents who may have vulnerabilities or complex medical conditions. The Health Links initiative has enabled providers to take on more of the high needs, complex residents in our region to ensure they have a primary care provider to manage their health needs. Additionally, having a local site for medical training has enabled more physicians to train locally, which has resulted in more new graduate physicians choosing to practice in the Waterloo Wellington region. According to the 2015 Resident Survey, 98% of adult residents have a primary care provider. This leaves somewhere between 17,000 and 41,000 residents in Waterloo Wellington LHIN who are not attached to a primary care provider. The Kitchener-Cambridge-Waterloo region has the highest volume of unattached residents.

We continue to create equitable and accessible health care solutions for our residents. There are four Health Links across Waterloo Wellington who provide wrap-around care for those residents with the highest needs; as of May 2015 almost 1,600 care plans have been developed for high needs residents. Many of these high needs residents are vulnerable and have difficulty managing what are complicated system transitions that can lead to them slipping through the cracks. Identifying the high needs residents and developing wrap-around care that not only includes health care providers, but also the broader community, will coordinate care for these residents to ensure they receive appropriate care and are able to effectively manage their health needs.

Mental Health and Addictions continues to be a key priority for our health care system. In the coming year, we will be working with our providers and residents to improve access to concurrent services for residents with mental health and addictions. Improved coordination and access to housing for residents with mental health and addictions issues, as well as supports within housing, will improve care and outcomes for those most in need.

Chronic Disease Prevention and Management (CDPM) strategies are key drivers to our system plan in providing appropriate, accessible and equitable care for residents in need. Improving access and implementing best practice guidelines for residents with diabetes will continue to be a priority. This next year, we will also expand the focus on the CDPM work in Waterloo Wellington LHIN to focus on chronic heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The Waterloo Wellington LHIN senior population is expected to increase over the next ten years by 53,000 people. By 2035, it is expected that there will be over 220,000 senior residents in Waterloo Wellington LHIN.

As the population ages, having effective CDPM programs that are accessible to our population is important to enable residents to prevent and manage chronic conditions. Through engagement with providers and expert panels, we know that we can improve the coordination and accessibility of mental health services in our region.

We will continue to work with our hospitals and community providers to improve the resident experience for end-of-life patients and their families. The Waterloo Wellington LHIN's Integrated Hospice and Palliative Care Council is updating a work plan to enhance palliative care at home and out-of-hospital for Waterloo Wellington residents.

Access to timely diagnostic imaging services in Waterloo Wellington will remain a priority for 2015/16. Our system has growing challenges with respect to access to diagnostic services. Strategies will be implemented throughout the next year to reduce wait times and enhance quality, efficiency and appropriateness of clinical services.

Patient experience will continue to be a focus in next year's plan. We will continue to focus on improving access to timely, equitable care in the community and in acute care settings. Newly released survey information indicates that in Waterloo Wellington more residents have a primary care provider, however, timely access to the provider and patient experience when they meet with their provider need to improve.

We will also continue working with our providers to implement provincial and local strategies that will improve patient transitions and information sharing. Progress was made over the past year to increase sharing of patient information, but this work must continue to ensure that appropriate follow-up care can be provided when necessary and decrease the need for the resident to tell their story more than once.

PROGRESS THROUGH THE EYES OF A FAMILY

Last year, we introduced you to the Thomas family from Guelph. Pam, a single mom, was doing everything she could to meet the complex health needs of her family. Her son Michael was struggling with mental health and addiction issues after his grandfather's stroke. Her mom was living in a long-term care home with Alzheimer's disease. Pam herself has diabetes and she was caring for her father after his stroke in her home. Her daughter Sara fell and broke her arm. The complicated health needs of the Thomas family are representative of those of thousands of other families across Waterloo Wellington.

ONE YEAR LATER – HOW ARE THEY NOW?

A priority for Pam over the last year was to take better care of herself. Working two jobs and the stress of caring for her family meant her diabetes wasn't being well managed. Through the help of her new family doctor at the Guelph Family Health Team and the Waterloo Wellington Diabetes Program, Pam attended education classes, learned about nutrition and started exercising. Her diabetes is now well managed and her risk for other chronic diseases such as heart disease is much lower. Over the past year, referrals to the diabetes program have increased by 30% - meaning more people like Pam are receiving education and support and living healthier.

While Pam's dad received exceptionally high-quality care for his stroke that allowed him to go home with Pam faster, he had a number of other health issues that were far too complex for Pam to manage. He was visiting the emergency department on an almost weekly basis. Pam's family doctor connected them with the Guelph Health Link and a coordinated care plan was developed to wrap a variety of supports around him. Pam now has better support which is contributing positively to her health and her dad is receiving a multitude of supports at home and in the community.

Pam's mom has been thriving in long-term care with the Behavioural Supports Ontario program. She has also benefited from enhancements to the Nurse-Led Outreach Team program which provides additional primary care support in long-term care. This helps to prevent unnecessary visits to the emergency department (ED). Waterloo Wellington has the lowest rate of long-term care ED visits in Ontario.

Michael was connected to mental health supports through the new "Here 24/7" – the first centralized intake and referral for mental health and addictions programs in Canada. Since its launch, more than 11,500 residents have been supported.

Michael was able to receive help for both his mental health concern and his addiction. With the expansion of telemedicine services, he was also able to have a consult with a child psychiatrist close to home in Guelph without having to travel to Toronto. He is doing better in school and even joined a sports team again for the first time in many years.

Lastly, Sara is doing great. Her arm healed with the support of the orthopedic clinic team at Guelph General Hospital. Her family is doing better which makes her happy and she is receiving regular care from her primary care doctor. In fact, when she was sick earlier this year she was able to get in to see her doctor the same day – which meant she was able to receive treatment sooner and was back to school faster.

The progress in the health of the Thomas family demonstrates how even those faced with many challenging health issues can thrive with the right supports. When the health system works together to better support individuals – their families and the entire community benefits.

PLAN FOR THE YEAR AHEAD

2015/16 is the final year in the current Integrated Health Service Plan, the year that we complete delivery on the objectives for system improvement identified as top priorities by our residents and health service providers. The pages ahead outline the key initiatives that health service providers across the LHIN will be focused on completing and the outcomes we plan to achieve.

MEETING THE NEEDS OF OUR DIVERSE POPULATION

As part of our plan development, we consulted with a number of specific groups including our French-speaking and Aboriginal Communities.

As we move forward with our plan, we will continue to focus on incorporating equity into everything we do.

We, and our health service providers, need to take a more intentional focus on those who tend to have poorer health outcomes such as those who live in poverty and those with fewer social supports. Improving the health of a population requires an explicit focus on narrowing the health outcome equity gap.

We will continue to ensure that the unique health needs of our diverse population groups, including our French-speaking and Aboriginal residents, are considered as new solutions are put into place.

FRENCH LANGUAGE SERVICE PLAN

The Waterloo Wellington LHIN has an estimated French-speaking population of 12,000 residents according to the latest data available through the Health Analytics Branch, Ministry of Health and Long-Term Care. As new immigrants make up the majority of new French-speaking people in our region, the increased diversity of the French community forms an important part of our planning. In the absence of designation under the French Language Service Act of Ontario, the Waterloo Wellington LHIN, in line with its core value of acting in the best interest of our residents' health and well-being, continues to address the needs of the French community within the core programs and services while developing specific initiatives for the most vulnerable segments of the population.

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 Plan for 2015-2016 includes:

- Continue to improve mental health services for all residents and in partnership with immigration services in the region, respond to the more distinctive needs of this population.
- Continue to work in partnership with the Waterloo Wellington Hamilton Niagara (WWHN) French Language Planning Entity to address the specific needs of the French-speaking community related to chronic disease management as well as culturally appropriate palliative care.
- Work in partnership with service providers and the Planning Entity to better respond to the needs of the older adult population and enable them to live in the community.
- Support the CCAC in implementing a comprehensive range of community services in French.
- Work in partnership with other agencies and ministries to support and complement services being offered by each sector such as education, children and youth services and public health.

- Consider the advice of the French Language Planning Entity in local planning.

The work planned for 2015-2016 will reflect the Joint Action Plan developed with the Planning Entity as well as the information gathered from the three French Health Forums held over the last year.

ABORIGINAL SERVICE PLAN

The Aboriginal residents of Waterloo Wellington include a culturally diverse community of approximately 10,000 people according to the National Household Survey 2011. The majority of these individuals reside in urban centers across the region. Local experts within the community tell us that the number is much higher as many within the community do not identify themselves as Aboriginal.

This population is one of the fastest growing within Canada - with about four times the number of births - and youngest population median age 27.7 compared to 40.6 (non-Aboriginal). Urban Aboriginal people are facing serious health issues, including higher rates of family violence, incarceration, mental health and addictions, chronic disease, poverty, suicide, apprehension of children and infants, unstable housing, unemployment and infant mortality rates, food insecurity and challenges within the education system. Aboriginal people face an unequal burden of health compared to non-Aboriginal people, including the social determinants of health.

As the Waterloo Wellington LHIN continues to implement its strategic direction of acting in the best interest of residents' health and well-being, the work of the Aboriginal Health and Wellness program over the last year has allowed us to develop a more comprehensive community engagement with the Aboriginal community while creating a more positive relationship with all partners. Meetings held with various segments of the population, including a group of elders, has enabled us to identify better ways to set-up priorities and ensure the active participation of the Aboriginal population in all planning activities. The Aboriginal Wellness Circle will guide us in developing an Aboriginal Health Strategy that will guide us in better responding to the needs of the community.

Over the coming year, while we develop the Aboriginal Health strategy and plan of action, the Waterloo Wellington LHIN will take the lead in supporting a regional, multi-sectorial group to find solutions to the pressing problems of homelessness related to mental health and addiction among Aboriginal residents. In fall of 2014, the Region of Waterloo published the homelessness report which identified that over 14% of homeless people were Aboriginal residents. It is our hope that this multi-sectorial table will facilitate the creation of effective partnerships to address housing and health issues among the Aboriginal community.

The Waterloo Wellington LHIN continues on an on-going basis to encourage all service providers to improve the cultural competency of staff. We will continue to encourage cultural competency training including the provincial Indigenous Cultural Competency program.

STRATEGIC PRIORITIES FOR OUR LOCAL HEALTH CARE SYSTEM

While improvements have been made in our health care system, there is much work still to do. Following are the priorities for the coming year as we continue along a roadmap that was set out in the government approved Integrated Health Service Plan – Better Health, Better Futures (2013 – 2016). This Annual Business Plan will serve as a guide for our staff and our health service providers for how we will work to improve health care for our residents over the next year.

OUR PRIORITY: ENHANCING YOUR ACCESS TO PRIMARY CARE

One of our three key local priorities is to ensure our residents have access to a primary care provider such as a family doctor or nurse practitioner, and that primary care providers across the Waterloo Wellington LHIN are well connected with other health service providers to offer the best care possible.

Evidence shows that comprehensive, accessible care with a focus on chronic disease prevention and management reduces avoidable emergency department visits and hospitalizations and improves overall health for residents.

Ontario's Action Plan for Health Care recognizes family health care as the hub of our health system. A strong relationship between our residents and our doctors, nurse practitioners and other primary care providers is the foundation in building an effective and efficient health care system – one that achieves better health, better care and better value and brings Waterloo Wellington one step closer to being the best place to live and grow old in. Ensuring that every Ontarian who wants one has a primary care provider will be a high priority.

We will continue to expand our cross-sector work with police, education, social service agencies, municipalities and more to address the social determinants of health. We will expand the tangible benefits of our Connectivity Tables and make strategic investments in initiatives that positively impact population health outcomes. We will take a more intentional focus to help those who tend to have poorer health outcomes such as those who live in poverty and those with fewer social supports. Improving the health of a population requires an explicit focus on narrowing the health outcome equity gap.

THE OPPORTUNITY:

To ensure all residents have a primary care provider such as a family doctor or nurse practitioner and that primary care providers are well connected with other health service providers.

KEY INITIATIVES TO ACHIEVE OUR STRATEGIC PRIORITY:

Establish family health care as the hub of the health care system to improve your access to services and positive health outcomes.

- Health Links
  - Build on the four Waterloo Wellington Health Links to improve coordinated access to care for residents with complex conditions.
  - Ensure residents with complex conditions have access to primary care.
- Social Determinants and Collaboration Outside of Health Care
  - Continue to grow partnerships amongst and between health, housing, social services, education, justice and other community partners to improve population health.
  - Identify more effective support for those at risk in our community through efforts such as Connectivity/Situation Tables.

Improve timely access to primary care.

- Access to Care Close to Home/Enabling Technologies
  - Review and optimize use of telemedicine and telehomecare

Develop and implement a model for community-based chronic disease prevention and management.

- Chronic Disease Prevention and Management and Diabetes

- Improve access and implement best practice guidelines for diabetes care and chronic disease prevention and management focused on congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).

Improve timely information sharing between primary care and other providers.

- System Coordinated Access/Enabling Technologies
  - Build, enhance, and sustain coordinated access to services through the System Coordinated Access project which includes access to Community Support Services, Rehabilitative Care, Palliative/End of Life Care, Mental Health and Addictions services, Diabetes Education and others.
  - Support primary care in ensuring coordinated, equitable, informed access to specialist care and explore options for shared care planning.

Improve access to appropriate cardiac care.

- Cardiac Care
  - Improve access to appropriate levels of congestive heart failure (CHF) care in community, primary and acute care settings.

EXPECTED OUTCOMES FOR WATERLOO WELLINGTON RESIDENTS:

- High needs residents will have individualized coordinated care plans developed through a Health Link in Waterloo Wellington
- All complex patients within a Health Link will have a primary care provider
- Fewer residents will have to be readmitted to hospital for chronic conditions
- Fewer residents will be hospitalized for chronic medical conditions that can be treated effectively in community
- Residents will have more connections to health care services through coordinated access centres

POTENTIAL RISKS/BARRIERS TO SUCCESSFUL IMPLEMENTATION OF THE INITIATIVES:

- Health Links are an improved way to deliver existing service in a collaborative, coordinated way and not a new "program." Sustaining a long-term interest in collaboration may be challenging if early successes are not achieved.
- Some of the issues affecting the outcomes for high users are not related to health issues but to the broader social determinants of health, such as lack of supportive housing, which may not be solvable in the short-term or within the health care providers' services but is still within our sphere of influence.
- The success of a shared care plan is dependent on the resident and/or family taking an active role in their health care. Residents may be unwilling or unable to modify behaviours, or may have difficulty understanding the changes required (e.g. language issues, mental health issues, health literacy etc.).
- Engagement of physicians and other primary care providers who are in a non-FHT or CHC model is more challenging and may limit ability to expand services and programs to impact the broadest number of residents.
- Differing interpretations on privacy regulations may limit providers' willingness to share appropriate information.
- Improving the health of the population and rates and management of chronic

diseases will see results over the mid-to-longer-term and will require commitment and patience to experience the results.

- Implementing enabling technologies is dependent on numerous stakeholders provincially and locally. Timelines and uptake by providers may be negatively impacted due to numerous external factors.
- Coordinated access efforts must ensure that these services streamline and improve access to care and not add unnecessary steps or confusion.

KEY ENABLERS TO ACHIEVE OUTCOMES:

- Health Links will be an important structure to advance improvements in care for our residents with complex health needs including seniors, persons with mental health and substance abuse issues and others with complex conditions.
- Continued support from the Ministry of Health and Long-Term Care to remove barriers will allow our local team to build more links across the health system. Ontario's Seniors Strategy to improve quality of care and life for older Ontarians, the implementation of the Ontario Diabetes Strategy to improve quality of care for people living with diabetes, and the establishment of Health Links to support the high users of the health system are examples of provincial efforts guiding and supporting local efforts.
- Electronic sharing of clinical information will enable care providers from across the continuum of care to have up-to-date patient information and improve outcomes. Improved information sharing will support effective care planning for high needs residents.
- Health system management data and analysis that is closer to 'real time' will assist health system managers in deploying effective services focused on local needs.
- Waterloo Wellington LHIN Primary Care Physician Lead, Chronic Disease Prevention & Management Physician Lead and Enabling Technologies Physician Lead will assist in connecting with the diversity of primary care providers to help create a shared vision, and demonstrate the value of change, as well as supporting natural leaders and champions.
- The all-of-community approach to addressing the social determinants of health and chronic disease prevention and management will improve health outcomes for residents.
- Cross-sector partnerships identifying and improving care delivery for those most in need will support effective care planning for high needs individuals.
- Standardization of reporting practices and business tools used within and across sectors will assist in streamlining through coordinated access.

OUR PRIORITY: CREATING A MORE SEAMLESS AND COORDINATED HEALTH CARE EXPERIENCE

Over the years, our residents have told us they did not always know where to go to get the care they need. Some care providers said that even when they knew what care is needed, they often did not know the best place to send patients. In the transitions between providers there lies great risk to quality of care; this can often lead to repeat use of the health care system, whether it is emergency department visits or readmissions; or gaps in care which could negatively impact health outcomes. We've made improvements to coordinate services and make navigating the system easier but there is still work to be done. We need to integrate and coordinate even more services to create a fully seamless experience of care that ensures that our residents receive the right care, at the right place, at the right time.

The initiatives in this strategic priority, along with those in our other priorities for the local health system, will continue to transform the way that residents experience care, by redesigning the way care is delivered. By integrating care both within sectors and across the continuum of care for specific patient populations, we will improve the patient experience, improve the health of our population, and improve value for money within the local health system.

Through all this, we also need to ensure that residents have the information they need to make informed choices and are empowered to participate in planning for their own care.

THE OPPORTUNITY:

To create a seamless experience of care to generate better health outcomes and ensure residents get the right care, at the right place, at the right time; and ensure support for those with the most complex health care needs.

KEY INITIATIVES TO ACHIEVE OUR STRATEGIC PRIORITY:

Integrating services to improve experiences and health outcomes by streamlining access to similar types of care and services (horizontal integration), coordinating access across organizations involved in the health care journey (vertical integration), and ensuring seamless, coordinated care in the community (geographic integration).

- Community Care
  - Establish efficient and integrated personal support service delivery for residents in the community.
  - Improve health outcomes and experience for residents by increasing timely access to equitable and integrated community services.
- Seniors Care
  - Continue to improve care for seniors through effective assess and restore services, dementia and Alzheimer strategies and improving access to specialized geriatric services.
- Patient Transitions
  - Improve patient experience and flow by integrated discharge and patient transition practices, including patients with mental health conditions and addictions from hospital.
- Alternate Level of Care
  - Remove barriers for people waiting for an alternate level of care (ALC).

EXPECTED OUTCOMES FOR WATERLOO WELLINGTON RESIDENTS:

- Following service authorization, residents will wait no more than five days for in-home nursing and personal support worker service.
- Residents will spend fewer days in hospital when they should be receiving their care in a more appropriate location.
- Residents will experience timely access to long-term care assessments.

POTENTIAL RISKS/BARRIERS TO SUCCESSFUL IMPLEMENTATION OF THE INITIATIVES:

- As individuals remain in the community longer, community providers are serving higher acuity patients; community services need to adapt to support the level of acuity they are seeing within their organizations (e.g. human resources, program design, etc.).
- The health and well-being of residents must be placed before the needs of individual organizations.
- Differing interpretations on privacy regulations may limit providers' willingness to share appropriate information.
- Design based on resident experience may challenge current ways of providing service and require openness to and implementation of significant change.

KEY ENABLERS TO ACHIEVE OUTCOMES:

- Health service provider Boards consider the system perspective including better health, better care and better value for residents to assist in identifying and prioritizing system integration initiatives.
- Existing collaborative networks and councils, both locally and provincially, will be keys to assess and drive out change in the system.
- Identification of duplication and streamlining services will free up capacity to provide more services to residents.

OUR PRIORITY: LEADING A QUALITY HEALTH CARE SYSTEM USING EVIDENCE-BASED PRACTICE

The nature of health care 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. There has been a growing mismatch between the needs of patients, the best-practice evidence regarding care provision and the design of the health system. The health system can be improved not only to provide better quality of care and value for money, but also to be easy for residents to navigate. The time for more significant change is now.

As we collectively transform the health system we need to do so in a way that improves quality, takes the confusion out of the system for residents and delivers better value for the money spent. We'll do this by consistently applying what clinical and research evidence tells us works – often called "evidence-based" practice.

Waterloo Wellington uses an integrated clinical program model to identify a single standard of care that is based on best practice evidence for specific patient groups. An integrated clinical program ensures the same standard of care and access to service for residents regardless of where they may receive that care.

In Waterloo Wellington we have implemented several integrated clinical programs such as those for stroke and cancer care. In the past, services were fragmented across Waterloo Wellington and patients might have received different treatments based on where they happened to live or how they accessed the system. Because of our efforts, that's not the case anymore. Local services for stroke and cancer care are organized as regional programs and all residents receive the same access and high standards of care. Quality and patient outcomes are also carefully monitored to help us understand what's working and why and what still needs to be changed.

THE OPPORTUNITY:

To identify and use evidence-based practice to redesign our health system, ensuring quality care and better health outcomes.

Quality care is determined by*:

ATTRIBUTES	OUTCOMES FOR RESIDENTS
Accessible	People should be able to get the right care at the right time in the right setting by the right health care provider.
Effective	People should receive care that works and is based on the best available scientific information.
Safe	People should not be harmed by an accident or mistakes when they receive care.
Patient-centred	Health care providers should offer services in a way that is sensitive to an individual's needs and preferences.
Equitable	People should get the same quality of care regardless of who they are and where they live.
Efficient	The health system should continually look for ways to reduce waste, including waste of supplies, equipment, time, ideas and information.
Appropriately Resourced	The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people's health needs.
Integrated	All parts of the health system should be organized, connected and work with one another to provide high-quality care.
Focused on Population Health	The health system should work to prevent sickness and improve the health of the people of Ontario.

* Quality Improvement Guide, Health Quality Ontario.

We know that a person's health goes beyond their physical health and is impacted by so much more than just the health system. Increased investments and shorter wait times for mental health services, including housing and employment supports to help people with their recovery will gain increasing attention in the coming period.

Improving the health system is not just the work of one organization; every health provider has a duty to make the system work better for residents. The Waterloo Wellington LHIN and health service providers are working together to make these important improvements to the system. We need to keep our momentum going.

KEY LOCAL HEALTH SYSTEM INITIATIVES TO ACHIEVE OUR STRATEGIC PRIORITY:

Implement evidence-based practices to ensure the same high-quality standard of care is provided across all sites for similar services.

- Quality Improvement
    - Accelerate best practice care through the system-wide adoption of electronic clinical order sets for Quality Based Procedures.
    - Enhance quality and ensure delivery of best practice through current integrated programs and implement new integrated programs.

Expand and enhance integrated programs that ensure quality and deliver best practice care across the continuum of care. Key improvements will include:

- Palliative Care
  - Improve the end-of-life experience for palliative residents and their families by ensuring options for people to die in the place of their choice.
  - Support advance care planning processes across the continuum of care and throughout the community.
- Long-Term Care
  - Improve the quality and safety of care in Long-Term Care homes.
- Emergency Department
  - Continue implementation of best-practices in Emergency Department care.
  - Improve care and experience for mental health and addictions patients.
- Mental Health and Addictions
  - Ensure all residents have access to complexity capable services at the right time, in the right place.
  - Improve access to intensive mental health services including optimizing Assertive Community Treatment Teams and support coordination.
  - Expand availability of mental health and addiction supports in housing.
- Pharmacy
  - Implement protocols for anti-microbial stewardship.
- Diagnostic Imaging
  - Reduce duplicate diagnostic imaging procedures.
  - Reduce wait times for diagnostic imaging procedures by optimizing service delivery models.
- Critical Care
  - Implement standardized clinical protocols and ICU best-practice design.
  - Develop and implement long-term ventilation program standards.
- Surgery
  - Improve access to specialized vision (eye) care and promote seamless eye care experience by strengthening the relationships between primary care, ophthalmology and optometry.

EXPECTED OUTCOMES FOR WATERLOO WELLINGTON RESIDENTS:

- Residents will have the ability to die at home or within a community setting rather than in hospital
- Residents will experience improved quality and safety of care in Long-Term Care homes
- Residents will receive non-urgent Cardiac By-pass Surgery (CTAS IV) within 84 days

- Patients requiring admission from the emergency department will be transferred to a hospital bed in 8 hours or less
- Patients with complex needs requiring care in an emergency department will be seen and sent home in 7 hours or less
- Patients with minor, uncomplicated needs requiring care in an emergency department will be seen and sent home in 4 hours or less
- Fewer residents will have repeat visits to the emergency department for Mental Health Conditions
- Fewer residents will have repeat visits to the emergency department for Substance Abuse
- Residents will receive non-urgent hip replacements (CTAS IV) within 26 weeks
- Residents will receive non-urgent knee replacements (CTAS IV) within 26 weeks
- Residents will receive non-urgent cancer surgery within (CTAS IV) 12 weeks
- Residents will receive non-urgent cataract surgery within (CTAS IV) 26 weeks
- Residents will obtain non-urgent MRIs (CTAS IV) within 4 weeks
- Residents will obtain non-urgent CT (CTAS IV) scans within 4 weeks

POTENTIAL RISKS/BARRIERS TO SUCCESSFUL IMPLEMENTATION OF THE INITIATIVES:

- Stakeholder support and leadership is needed to ensure a full and smooth implementation.
- A number of funding models that are important for supporting system improvements fall outside of the purview of the LHIN such as emergency physician funding models and Hospital On-Call Coverage Program (HOCC).

KEY ENABLERS TO ACHIEVE OUTCOMES:

- Quality Based Procedures and the related quality expectations are important drivers of quality improvements and the health and well-being of residents.
- Ministry of Health and Long-Term Care support in the transition from provider-focused lump-sum funding towards a far more transparent patient-centred model, where funding is based on the quality of the care provided, will continue to evolve and support better care, better health and better value.
- Collaboration through integrated programs including providers across the continuum of care and engaging patients/residents in the system change will improve the residents' experience and health outcomes.
- Data developed through centralized resources such as Cardiac Care Network, CritiCall Ontario, and others support the Integrated Councils in understanding the local service landscape and priorities for system improvement.
- Collaborating with local post-secondary institutions, such as Conestoga College, will assist with improving quality of care now and into the future.
- System collaboration and partnerships, especially among inter-Ministry stakeholders, will support a more holistic approach to care delivery (including non-health care resources, such as housing) for high needs residents, such as persons with mental health and substance abuse issues.
- Optimizing integration opportunities to provide more seamless transitions and standard quality of care.

ACCELERATING SYSTEM CHANGE: THE TIME TO ACT IS NOW

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 our residents.

We know that the timely achievement of results for all of our residents is dependent on our being able to quickly remove barriers to change, and support the transformation of the system, by putting our residents' health and well-being first.

A focus on accelerating integration, funding reform and the use of appropriate enabling technologies that clinicians want and will use, are all examples of actions that are underway both locally and provincially.

Barriers to success will be quickly removed to ensure we generate better health, better care and better value for our residents. A transformed system is within reach. To enhance this, we will build knowledge and skills capacity throughout the system in four key areas to support the Integrated Health Service Plan: leadership through good governance, quality care, resident-centered care, integrations and organizational collaboration.

We will build more links across the health system through governor-to-governor engagement and the with the support of those who champion integration.

We will work with community leaders to address the root causes of poor health and health equity for our residents. We will use tools that support clinical and operational decision making, to improve system flow and get you timely and well-informed care throughout your life-long health care experience.

The Patients First: Action Plan for Health Care calls for an increased focus on informing people including providing people with the education, information and transparency they need to make the right decisions about their health. New online resources to help people prevent illness, including a tool that assesses cancer risk and provides a personalize prevention plan and expanded patient engagement and consultation across the health care system are examples of how this will happen.

The province will introduce new best-in-class public reporting on areas like wait times, public drug programs and mental health to measure how the health system is performing, improve transparency and shine a light on where improvements are necessary will help accelerate positive change.

LOOKING AHEAD – ONE FAMILY'S EXPERIENCE

We have an ambitious plan to improve the health system in 2015/16 which may be best understood through the eyes of our residents. What will full implementation of the 2015/16 Annual Business Plan mean for residents of Waterloo Wellington? Let's consider the Ramos family…

The Ramos family lives in Cambridge. Anna (22) has two children, Miguel who is five and Mya who is three. Anna has stayed home since having Miguel and they live with her boyfriend Tyler (24) in an apartment. Tyler works in the manufacturing sector and money has been really tight supporting the four of them. However, his biggest stress is his mom, Maria.

Maria often sleeps on the couch in their tiny two-bedroom apartment. She lives with her boyfriend, an alcoholic who abuses her. When Maria stays with Tyler, her boyfriend will sometimes show up under the influence and threaten the family. When this happens, Anna packs up the kids and heads to her mom's house and Miguel misses school for a few days. Maria has turned to prescription painkillers for coping. She is unemployed and has Chronic Obstructive Pulmonary Disease (COPD) a chronic lung condition that makes it difficult to breath.

HOW WE WILL BETTER CARE FOR THE RAMOS'?

The Ramos family's health needs are representative of many other families across Waterloo Wellington. Their needs, however, are not solely within the health care system. They require support from the education system, social support system, community safety services such as the police, employment services and more. How well they are supported by all of these sectors will impact their health far greater than health care services alone.

The Waterloo Wellington LHIN's strategy includes improving access to health care services for the Ramos' but it also reaches beyond, collaborating with other sectors to address the social determinants of health to improve the health and well-being of local residents. One example is connectivity tables – where all of our public service agencies come together to collectively identify individuals at elevated risk (like Maria) and work together to wrap supports around the entire family.

ENHANCING ACCESS TO PRIMARY CARE

Access to regular and consistent primary care is essential to the health of the Ramos family. The Waterloo Wellington LHIN is investing additional funding in Community Health Centres (CHC) to support them in taking on more patients. In Cambridge, Langs CHC could then enroll the Ramos family to provide them with access to primary care and a range of other social supports. While more than 90 per cent of residents in Waterloo Wellington have a primary care provider, there is much work to be done in enhancing the experience of residents when receiving primary care. For example, how easily care can be accessed after hours and on weekends. Over the next year, work will continue on Health Links to better support those with the most complex care needs in our community. Coordination and implementation of best practice guidelines for COPD will better support Maria in managing her disease, while work on expanding system coordinated access to other areas of the health system will also help the Ramos' and their new primary care team connect them with the care they need faster and more efficiently.

CREATING A MORE SEAMLESS AND COORDINATED HEALTH CARE EXPERIENCE

As residents like the Ramos' receive care from different parts of the health system, the transition between providers needs to be as seamless as possible. This means many different providers need to work together. Tyler's grandfather Raul is showing early signs of dementia; he also needs a knee replacement. Raul is also having trouble with his vision and will need cataract surgery. A review of personal support services this year will identify areas of improvement to better support Raul in his home. And investments in geriatric services means Raul will be able to see a geriatrician sooner when needed, as well as access specialized day programs and enhanced supports for his dementia. Work on better coordinating access to specialist care, community support services and rehabilitative care, will also improve efficiency and enhance the care experience for Raul and his family.

IMPROVING THE QUALITY OF CARE YOU RECEIVE

We talk a lot about improving quality - but what does quality actually mean? Quality health care means that the care you receive is: safe, effective, accessible, equitable, efficient, sensitive to your needs, integrated, appropriately resourced and focused on preventing illness as much as treating illness.

One way we improve quality is by connecting programs and services through what is officially termed integration. Integration is about ensuring the same standard of care is provided in all locations, and improving the patient experience. This way, no matter where a family lives, or who they are, they will receive the same quality of care. Integration also increases efficiency, freeing up resources that can be reinvested into other programs.

One example of integrated care locally is the cardiac program at St. Mary's General Hospital. Here, all residents in Waterloo Wellington have access to some of the highest-quality cardiac care in the country based on best practice. That level of care is being expanded to other areas through the development of integrated programs, as well as the implementation of clinical order sets – an electronic system to integrate the latest best practices for the best health outcomes of those patients. A new Waterloo Wellington vision care strategy will also improve the care Raul receives when he needs his cataract surgery.

A significant focus will be placed on enhancing palliative care so that when the time comes, Raul and others can experience the end-of-life care that best matches their wishes. This includes improving advance care planning – educating and engaging the public and caregivers on the need to have conversations about end-of-life care sooner. It will also free up resources in hospitals for those who truly need to be there.

Additionally, efforts will continue in reducing emergency department wait times, improving quality in long-term care, and much, much, more.

WATERLOO WELLINGTON LHIN OPERATIONS

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 (LHINC).

THE WATERLOO WELLINGTON LHIN OPERATIONS SPENDING PLAN ASSUMES THE FOLLOWING FOR 2015-2016:

- 37 FTEs.
- Total Employee Benefits as 20% of Salaries and Wages.
- Sustained base revenue from 2014/15

WATERLOO WELLINGTON LHIN OPERATING BUDGET

WWLHIN OPERATING BUDGET FOR FISCAL YEAR 2015/2016

	2015/16 Budget	2014/15 Forecast (Dec 2014)	2014/15 Budget	2016/17 Budget	2017/18 Budget
REVENUE					
Operating	4,198,719	4,198,719	4,198,719	4,198,719	4,198,719
Diabetes RCC	1,036,138	1,057,284	1,057,284	1,036,138	1,036,138
Total Base Revenue	**5,234,857**	**5,256,003**	**5,256,003**	**5,234,857**	**5,234,857**
Aboriginal Planning	5,000	5,000	5,000	5,000	5,000
eHealth Ontario	510,000	510,000	510,000	510,000	510,000
French Language Health Services	106,000	106,000	106,000	106,000	106,000
ED Lead	75,000	75,000	75,000	75,000	75,000
Critical Care Lead	75,000	75,000	75,000	75,000	75,000
Primary Care Lead	75,000	75,000	75,000	75,000	75,000
ED/ALC Lead	100,000	100,000	100,000	100,000	100,000
Total One-Time Revenue	**946,000**	**946,000**	**946,000**	**946,000**	**946,000**
TOTAL REVENUE	**6,180,857**	**6,202,003**	**6,202,003**	**6,180,857**	**6,180,857**
EXPENSES					
Salaries & Benefits	4,758,857	4,263,005	4,814,943	4,758,857	4,758,857
Salaries, Wages, Benefits	**4,758,857**	**4,263,005**	**4,814,943**	**4,758,857**	**4,758,857**
Communications & Comm Engt	45,000	157,500	65,600	45,000	45,000
Consulting Services	150,000	300,000	150,000	150,000	150,000
Supplies	30,000	58,500	57,333	30,000	30,000
Mail, Courier, Telecomm	52,000	50,500	40,000	52,000	52,000
Travel	40,000	40,000	40,000	40,000	40,000
Printing & Translation	52,000	56,500	45,000	52,000	52,000
Training & Development	56,000	78,500	59,000	56,000	56,000
Computer Equipment	55,000	87,500	49,303	55,000	55,000
Direct Operating Costs	**480,000**	**829,000**	**506,236**	**480,000**	**480,000**
Occupancy	325,000	385,000	324,719	325,000	325,000
Shared Services	404,500	403,700	341,620	404,500	404,500
LHIN Collaborative	47,500	47,500	47,500	47,500	47,500
Other Fixed Costs	**777,000**	**836,200**	**713,839**	**777,000**	**777,000**
Board Chair Per Diems	70,000	70,000	72,800	70,000	70,000
Board Per Diems	45,000	30,000	48,250	45,000	45,000
Board Travel	10,000	11,000	8,750	10,000	10,000
Other Governance Costs	40,000	31,000	37,185	40,000	40,000
Governance Costs	**165,000**	**142,000**	**166,985**	**165,000**	**165,000**
TOTAL EXPENSES	**6,180,857**	**6,070,205**	**6,202,003**	**6,180,857**	**6,180,857**
TOTAL SURPLUS/(DEFICIT)	**0**	**131,798**	**0**	**0**	**0**
FTE	**37**		**37.5**	**37**	**37**

LHIN STAFFING PLAN (FULL-TIME EQUIVALENTS)

Position Title	2014/15 Actuals as of Mar. 31/15 FTEs	2015/16 Forecast FTEs	2016/17 Forecast FTEs	2017/18 Forecast FTEs
Administrative Support	6	6	6	6
Professional	7	9	9	9
Manager	1	1	1	1
CEO	1	1	1	1
Senior Management	2	3	3	3
Management/ Senior Expert	16	17	17	17
Total FTEs	33	37	37	37

COMMUNICATIONS & COMMUNITY ENGAGEMENT PLAN

BACKGROUND/CONTEXT:

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 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 (IHSP 2013-2016) identifies three strategic priorities of focus: improving access to care, improving coordination and integration of care and improving quality of care. A number of system improvement initiatives have been identified within each of the three priorities.

COMMITTED TO IMPROVING THE PATIENT EXPERIENCE

The Waterloo Wellington LHIN is driven by acting in the best interest of the health and well-being of its residents. Aligned with the province's mandate and the Action Plan for Health Care, our Integrated Health Service Plan (IHSP) and Annual Business Plan (ABP) are grounded in patient-centeredness. The Waterloo Wellington LHIN puts residents first in every discussion and every decision. This requires a comprehensive understanding of the needs of local residents and the development of local solutions to best meet those needs. The Waterloo Wellington LHIN accomplishes this through communication and community engagement with residents and key stakeholders.

Just as the Waterloo Wellington LHIN needs to understand its residents, it is important that residents and other stakeholders understand the role and work of

the organization charged with transforming the system. In the past there have been low levels of understanding. For instance, a 2012 survey reported that two-thirds of Waterloo Wellington residents said they had never heard of the Waterloo Wellington LHIN, while just over one-in-ten said that they were at least somewhat familiar with the organization.

As significant efforts are made to improve the health care system for local residents, it is becoming increasingly important to build support from residents as well as others involved in impacting the social determinants of health. Increasing awareness of the LHIN and its work will assist the Network and its health service providers in making the necessary changes to build a high-quality, integrated and sustainable health care system. It will also ensure the LHIN is in a position to help residents and others better understand the system they must navigate.

CLARITY, ALIGNMENT AND RESIDENT-FRIENDLY LANGUAGE

From a communications perspective, great strides have been made in using public-friendly language, and ensuring clarity and alignment in communications with our residents, our health service providers, and our other partners.

This integrated communication and engagement plan significantly advances this approach. It also focuses on initiatives that will reach strategic target audiences to spread provincial and local LHIN key messages, enhance awareness and understanding of both the Waterloo Wellington LHIN and the health system. It will also contribute towards the achievement of the provincial mandate for health, long-term care and wellness and our ABP initiatives.

OBJECTIVES:

Through this communications and community engagement plan, the Waterloo Wellington LHIN seeks to inform, educate, consult, involve, collaborate with, and empower its various stakeholders. We need to have a clear understanding of the priorities and experiences of the communities we serve. We also require our stakeholders to have a good understanding of its role, the need for change in the health care system, and the progress that has been made to date.

These objectives are well aligned with the Ministry of Health and Long-Term Care's goal to build a health care system around the needs of our patients and communities. Increasing awareness and input from stakeholders will help keep residents healthier, increase access to care, and help residents receive the right care, at the right place, at the right time.

- To increase awareness and understanding of the Waterloo Wellington LHIN's role - leading a high-quality, integrated health system for its residents.
- To engage residents and other stakeholders in identifying the changes needed in the health system, especially from a patient experience perspective.
- To prepare residents for upcoming changes to the way health care services are organized and delivered to improve quality of care.
- To ensure that the information our residents need to make good choices to support their health and receive the care they need is available and accessible.
- To highlight past and current achievements to promote progress, at the same time building understanding of the future changes needed to improve care for residents.

TARGET AUDIENCES:

As we focused on meeting the needs of its residents, input and support from a variety of stakeholders is needed. Our diverse stakeholders have different understandings of the health care system and the role of the LHIN in planning, integrating and funding the system. We have identified the following stakeholder groups as key areas of focus communications and engagement.

- Local residents (with a focus on diversity and accessibility, including Aboriginal and Francophone residents)
- Our local health service 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
    - Police/Community Safety
    - Social Services Sector
    - Post-secondary education
    - Others
- Internal to the Waterloo Wellington LHIN
    - LHIN Board of Directors
    - LHIN Staff
- WWLHIN Advisory Groups and Local Provider Networks
    - Local Community Council
    - Local Health Professionals Advisory Council
    - Primary Care Advisory Committee
    - Various Networks/Councils (Addictions and Mental Health, Community Support Services, Geriatric Services, Emergency Services, etc.)
- Other external stakeholders
    - Elected officials
    - Media

KEY MESSAGES:

Transformational Messaging (MOHLTC)

1. Putting people and patients first by improving the health care experience.
2. Providing information to make decisions, and tools to live healthy and stay healthy.
3. Providing better access to quality health services, and protecting those services for generations to come.
4. Patients First:
    1. Access: Providing timely access to the right care
    2. Connect: Building an integrated system of care in the community and close to home
    3. Inform: Provide the information our residents need to make the best choices for their health and well-being
    4. Protect: Ensuring our universal health care system is sustainable for generations to come

WWLHIN KEY MESSAGES

- The Waterloo Wellington Local Health Integration Network's mission is to lead a high quality, integrated health system for our residents.
- 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 Waterloo Wellington LHIN is generating better health, better care and better value for taxpayers' dollars.
- The health system strategic priorities are: Enhancing Your Access to Primary Care, Creating a More Seamless and Coordinated Health Care Experience and Leading a Quality Health Care System Using Evidence-based Practice.
    - Enhancing Your 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 health system.
    - Creating a More Seamless and Coordinated Health Care Experience means integrating services to make it easier for residents to effectively navigate the care they need and access the right care, in the right place, at the right time.
    - Leading a Quality Health Care System Using Evidence-based Practice 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.
- The work of the LHIN supports the Patients First: Action Plan for Health Care which aims to provide the right care, at the right time, in the right place to ensure better patient outcomes.
- Above all, the LHIN is focused on protecting and improving the health and well-being of our residents.

- Everyone has a role to play in the change. We are working together with local residents, health care providers and others in our community to transform the way health care is delivered, accessed and funded. These changes are being made based on evidence, value-for-money and innovation.
- Improving the health and wellbeing of local residents involves much more than simply health care. The Waterloo Wellington LHIN is working together with local police, school boards, colleges and universities, social services and more, to break down silos and wrap services around those most in need.

To achieve its mandate, the Waterloo Wellington LHIN:

- brings providers together to better connect health services ;
- makes investments and funding decisions based on the needs of our residents;
- leads the creation of programs; and
- introduces measurements and targets, and holds health service providers accountable through service accountability agreements.

COMMUNITY ENGAGEMENT:

As outlined in the diagram below, Community engagement at the Waterloo Wellington LHIN is composed of three key pillars: Community Relations, Public Participation, and Patient Experience. The Waterloo Wellington LHIN engages its diverse community in a variety of different ways to obtain resident-focused inputs to enable system transformation.

The Waterloo Wellington LHIN will continue to engage its residents and stakeholders in a variety of formal and informal ways. We speak with our residents and stakeholders every day. This has great impact on our work and actively informs its decision-making process. We will utilize existing channels (ex. networks/councils/ website) and seek to develop new channels to proactively engage and communicate with stakeholders.

Specific effort will also be taken to engage our diverse population, including its Aboriginal and Francophone communities. We work with the Waterloo Wellington Hamilton Niagara French Language Health Planning Entity to identify the specific health care needs and priorities of francophone residents. The Waterloo Wellington LHIN also makes a number of its communications documents available in both official languages. As we continue to update ourwebsite, emphasis will be placed on adding bilingual content and improving accessibility for residents with disabilities. We are also working to increase accessibility by holding events in accessible locations and providing a variety of mediums for communications. We communicate and engage with local Aboriginal residents through a number of organizations that specialize in serving this population. Additional work will be done to identify additional opportunities for communicating and engaging with Aboriginal residents and addressing issues of health equity. More detail is provided in the ABP under the priority of creating a more seamless and coordinated health care experience.

Community Engagement

Community engagement refers to the methods by which LHINs and HSPs interact, share and gather information from and with their stakeholders. The purpose of community engagement is to enable the transformation of our health care system to one that is integrated, patient centred, high quality, and sustainable.

Resident-Focused inputs from providers, residents, and other stakeholders to enable system transformation.

Community Relations	Public Participation (P2)	Patient Experience
How we build relationships to increase awareness, obtain input/feedback, build community trust and profile/reputation.	*How we engage those affected by a decision in the decision-making process.*	*How we enable quality improvement and resident-centred care through engaging residents in improving their overall care experience and outcomes.*
Community Relations inputs build a foundation for P2.	*Participation inputs enable more effective decision-making and better meet the needs of our community.*	*Identifies system gaps, enables P2, and experience-based design which improves overall patient experience.*
	Effective P2 positively impacts reputation/trust.	

← All three influence the other →

TACTICS:

The following chart details analysis of the Waterloo Wellington LHIN's target stakeholders, as well as the various communications and community engagement tactics that will be utilized to reach the objectives in this plan. Overall, our approach is one of storytelling – engaging and educating stakeholders through stories that identify the need for change and demonstrate improvements being made to the patience experience. We will further refine its communications and engagement plan on an ongoing basis to ensure the right stakeholders are engaged, and to maximize the plan's impact, within available resources.

Stakeholder Group	Analysis	Communications	Community Engagement
Residents	• Low to Moderate (Mod) interest • Mod influence • Uninformed/ negative position • Potential endorsers • Educate/Inform/ Consult	• Newsletters • Social Media • Website • Videos • Community Report	• Surveys • Community Council • Resident Input/ Concern • Tracking • Community events
Health Care Service Providers	• High interest • High influence • Positive and negative position • Potential endorsers • Involve/Collaborate	• Newsletters • Social Media • Website • Videos	• Surveys • Special Events • Presentations • Attending board meetings, events, meetings, etc.
Influencing Organizations	• Low to Mod interest • Mod influence • Positive/Negative/ Uninformed • Educate/Inform/ Consult	• Newsletters • Social Media • Website • Videos	• Presentations/ Feedback Sessions • Leader/Leader and Board/ Board meetings
Internal	• High interest • High influence • Positive position • Collaborate/ Empower	• Sharepoint Intranet • Board Meetings • Daily Articles of Interest • Sharing of News/Info/ Issues • Town Halls	• Staff Meetings • Board and Committee Meetings • Staff and Board Surveys

Stakeholder Group	Analysis	Communications	Community Engagement
Advisory Groups/ Networks	• High interest • High influence • Positive and negative position • Potential endorsers • Involve/Collaborate/Empower	• Newsletters • Website • Videos • Meetings with Chairs	• Network Meetings • Engagement sessions
External (Government Relations/ Media)	• Mod interest • Mod influence • Positive and negative position • Educate/Inform/ Consult	• Newsletters • Email Updates • News Releases • Targeted Pitches	• Meetings/ Presentations with Government stakeholders • News Conferences • Relationship building with new media outlets

EVALUATION:

Evaluation is crucial to determine the success of the our communications and community engagement initiatives. We intend to conduct research as a means of evaluating current levels of awareness and resident/patient priorities compared to previous years. This will also serve as a catalyst for the development of new initiatives to better engage target audiences. Current evaluation tools include:

- Google and Web analytics
- Community engagement tracking and analysis
- Surveys
- Social media monitoring tools (Facebook insights, TweetReach, Bitly, YouTube analytics)
- Traditional media monitoring

Communications and community engagement events will be measured through: baseline and subsequent survey results, participation rates in community engagement activities, quantity and quality of communication outputs and media reporting.

Note: The Ministry of Health and Long-Term care has invested additional funding in the Waterloo Wellington LHIN for specific projects and the engagement of specific stakeholders. The Waterloo Wellington LHIN integrates the engagement for these initiatives into its overall annual community engagement plan.

ATTACHMENT: A
2014/15 ANNUAL BUSINESS PLAN
SUMMARY OF PLAN IMPLEMENTATION

Following is an overview of the 2014/15 Annual Business Plan and the outcomes from the past year.

OUR PRIORITY: ENHANCING YOUR ACCESS TO PRIMARY CARE

Establish individualized, coordinated care plans for high needs residents through Health Links across Waterloo Wellington

Health Links are a provincial, transformative innovation that provide coordinated local health care for high needs residents – those who often see multiple providers and find it difficult to navigate the health and other systems to meet their needs.

The four, ministry-approved Health Links covering Waterloo Wellington continue to develop and work through their business plans to meet the needs of the residents of our region. While excellent work and collaboration is underway to establish coordinated care plans for these residents, the target number of care plans will not be reached by year-end. The targets set were an estimation of what could be achieved in this experimental "new way of being" without the benefit of comparative data. Many operational lessons have been learned since the start of Health Links in late 2013 that can better inform realistic targets for next year. For example, more care plans were developed in the earlier stages of Health Link operations. As the caseload of residents with high needs increases for each Health Link, the teams have been challenged with care plan development.

The Health Links teams along with LHIN staff continue to work to better define and demonstrate impact to our residents through continuous quality improvement and intersection and alignment with other health system initiatives. As stated earlier, the Waterloo Wellington LHIN are also working closely with the ministry as the Health Links model matures.

Expand and improve upon streamlined, coordinated access to services across the continuum of care

The CCAC (system lead for SCA (System Coordinated Access) has completed its current state review for SCA through an external consultant. Future state plans are currently being reviewed by key sponsors and a gap analysis will be reviewed at the end of the fiscal. There has been agreement from the cluster for the Waterloo Wellington LHIN to take the lead on the project and to use an innovative procurement process to best facilitate the desired future state. eHealth Ontario has been involved in the review exercise to ensure alignment with the PRM (Provincial Reference Model) and Ontario's eHealth blue print. The Steering Committee has decided to issue a market sounding document and not a formal RFP (Request for Proposal), it is expected to be released in April 2015.

Build partnerships between health, social services, education, justice and other community partners to improve population health

Building on the success of the partnership between CMHA WWD and the Waterloo

Region Police Service in providing joint mobile mental health and addiction crisis services, CMHA WWD has brokered partnerships with both the Wellington Ontario Provincial Police as well as the Guelph Police. In the case of the Wellington OPP, CMHA WWD will be providing mobile dispatch services as well as is co-locating mental health and addictions workers to better support the needs of residents. This model of care has not only provided residents with an enhanced team of supports, but has reduced unnecessary visits to the emergency departments, drastically reducing time that police officers spend in transferring residents into acute services, but is also going a long way to seeing front line responders, such as police, EMS and fire as a part of a community based health care team.

Connectivity Tables/HUB Models continue to be operational in Cambridge, Guelph and in Kitchener/Waterloo, and have been helpful in providing wrap-around care planning for residents in high risk situations. Through a structured process of information sharing, agencies around the table collaborate to design a coordinated intervention that quickly meets the immediate and pressing needs of the individual or family within a 24-48 hour timeframe. The belief is that the existing system of individual agency / institutional silo support has been inadequate and through this collaborative intervention, all of resident's needs have the potential of being met, thus ultimately reducing risk more efficiently and effectively. Early successes are proving this philosophy to be true so far. Several table members have stated that they now think differently and are more proactive in their approach to all situations as a result of working collaboratively around the table.

The table below describes the activities of each Connectivity Table to date:

	Cambridge	Guelph	Kitchener
Number of situations brought forward	124	31	39
Number of situations closed/ resolved	101	28	30
Number of situations currently open	6	3	5
Number of situations declined	17	6	4

Further, a formal evaluation process of the program locally is underway to further understand the benefits of Connectivity and determine the areas that may require improvement.

Improve health equity through improved access to care close to home

Telehomecare: The Rural Wellington Health Links have plans for developing telehomecare for their patients. They have been working with Ontario Telemedicine Network to ensure an effective, sustainable plan for delivery.

Improve access and implement best practice guidelines for diabetes care and chronic disease prevention and management

Referrals to diabetes education programs from emergency departments were reviewed in mid 2014-15 identifying only 14% of those presenting to the ED with

a primary cause of diabetes were referred. A presentation was made to the ED council in September 2014 to highlight this data and flow of patients to DEPs via the central intake process. Since this time, the referrals to DEPs through central intake from EDs has increased 45%.

Readmissions for chronic conditions demonstrated an observed ratio 1.43% higher than expected in Q1 of 2014-15. Comparing the observed to expected readmission rates across LHINs, the Waterloo Wellington LHIN performs approximately at the median for this indicator. The average LHIN reported 43.3 additional observed readmissions beyond expected and the Waterloo Wellington LHIN reported 28 which was the 8th lowest in the province. The clinical cohorts with the largest difference between observed and expected rates were: Gastrointestinal, Cardiovascular, COPD and CHF.

A survey of services offered within the Waterloo Wellington LHIN by family health teams and community health centres targeted towards chronic diseases has been completed. An advisory group consisting of geographical representation throughout the Waterloo Wellington LHIN of primary care providers involving both those in FHTs and non-FHTs is being formed to develop a recommended strategy for CDPM within the LHIN. The initial meeting of this group is scheduled for April 23rd. Decision support has also been engaged to compare system performance by those providing enhanced models of care for CDPM for potential consideration of a broader strategy to manage these conditions.

Implement enabling technologies including:

Ontario Laboratory Information System (OLIS): eHealth Ontario is currently reviewing the schedules submitted by the Waterloo Wellington LHIN hospitals and will be scheduling meetings to discuss the Transfer Payment Agreements with them with a goal to have them signed by March 31, 2015.

Hospital Report Manager (HRM): The hospitals in the Waterloo Wellington LHIN will go live with Hospital Report Manager (HRM) throughout the spring and summer, starting with Grand River Hospital in March. Timelines have been established in partnership with OntarioMD and the remaining hospitals go live as follows:

St. Mary's General Hospital – April

Cambridge Memorial Hospital – July

Guelph General Hospital and North Wellington Health Care Alliance – July

HRM electronically delivers text-based Medical Record reports, (e.g. Discharge Summary) and transcribed Diagnostic Imaging (excluding image) reports from the hospitals directly into patients' chart, within the HRM-enabled clinician's Electronic Medical Record, enhancing patient care. The eHealth Centre of Excellence, as the connecting South West Ontario (cSWO) Program Change Management and Adoption Delivery Partner, continues to work collaboratively with OntarioMD to deploy HRM to eligible physicians and nurse practitioners in Waterloo Wellington so they can take advantage of this valuable information as local hospitals go live. The cSWO Program is a regional integration initiative funded by eHealth Ontario.

Technology supporting Health Links: Work is underway to begin training staff at three of the Health Links to use CCAC's Client Health and Related Information System (CHRIS) tool to capture the Care Coordinated Plans (CCP) electronically. This will allow better sharing of the CCP amongst all care delivery partners as the

form will be available at any point that CHRIS is accessed. This includes all CCAC staff, regardless of their physical location. This is a first step in making the CCP more widely available so those involved in a resident's care have access to the important components throughout the delivery of care. Guelph Health Links is part of a small group of Health Links that will be piloting the provincial electronic CCP tool and will be providing valuable assistance to the development of this tool prior to its release for all Health Links in the future.

OUR PRIORITY: CREATING A MORE SEAMLESS AND COORDINATED HEALTH CARE EXPERIENCE

Strengthen and maximize the current quality and capacity of community services

The Waterloo Wellington LHIN has contracted Lough Barnes Consulting Group to complete a review of personal support service delivery in Waterloo Wellington, with a focus on mapping the current state of services and identifying areas for improvement in access, navigation and efficient delivery. Consultation sessions with health service providers (management and board members) and clients are in progress, and feedback is being gathered and analyzed along with data on client need and service delivery targets. Recommendations from this review are expected at the end of March 2015. Lough Barnes Consulting Group has extensive experience in the community support service sector, and most recently have completed work in Champlain LHIN on re-aligning community services to improve quality. Due to our investment in this review, the Waterloo Wellington LHIN has been appointed to participate as a non-adopter in the provincial Early Adopters Group for the Transition of PSS clients from the CCAC to Community. The group will work on identifying best practices for this transition and we will work synergistically with this group as we move through our local process.

The Ontario Community Support Association (OCSA) in partnership with the Waterloo Wellington Community Support Services Network hosted a workshop on March 3, 2015, entitled Experience Based Design (EBD) Workshop: Using Client and Staff Experience to Design Better CSS Services. Subsequent to this workshop, the network will also host a complementary workshop for front-line staff, supervisors and managers to adopt and develop the necessary tools, templates and processes to support a person-centred culture within organizations.

Over the past two months, numerous one-time investments were made in the community sector to fortify the quality and capacity of CSS services in the Waterloo Wellington LHIN. These investments included financing hearing technology and other physical resources for CSS providers, best practice educational opportunities, providing temporary relief for intake and admissions pressures

in the ABI system, and investing in the quality and service delivery efficiency of meals on wheels and transportation services across the LHIN.

Remove barriers for people waiting for an Alternate Level of Care

There is a current and ongoing internal review of provider Alternative Level of Care (ALC) performance. These efforts are coupled with engagement with our providers to better understand ALC challenges and to identify opportunities for removing barriers and improving patient flow.

Improve care for seniors through implementing key recommendations of the Provincial Seniors Strategy

Assess and Restore projects for the 2014-15 fiscal year are now fully underway. Based on work that was completed in our LHIN prior to the current Assess and Restore investment, the Waterloo Wellington LHIN is designated lead LHIN for two projects: screening tool implementation and geriatric training.

The Assessment of Urgency Algorithm (AUA) screening tool quickly identifies frail seniors and stratifies based on risk. This tool, already in use at Grand River Hospital and by the CCAC, is being adopted and implemented in the Mount Forest FHT and New Vision FHT and referral pathways being developed based on risk level.

An expansion of the existing frailty eModules is also under development, with guidance from the Rehabilitative Care Alliance. These modules will serve to provide interdisciplinary education on geriatric syndromes with a purpose of increasing knowledge, capacity and competence in care teams across the province.

A number of new geriatricians and geriatric psychiatrists have been attracted to and are taking up practice in the Waterloo Wellington LHIN. The geriatric specialty steering committee continues to meet on a regular basis to discuss the integration of these specialized services in the broader system.

Improve the quality and safety of care in Long-Term Care Homes

Work continues in improving the quality and safety of care in Long-Term Care homes by improving the four indicators: the rate of falls, worsening incontinence, worsening ulcers and the use of restraints. Recent one-time investments in Long-Term Care facilities seek to improve outcomes for residents living with dementia and skin and wound issues. LHIN staff continue to work in partnership with the Long Term Care Network as well as individual homes and integrated programs to analyze these indicators and recommend ways to improve quality and safety throughout the system. Staff will also be working with the Long-Term Care network to encourage the development of an annual workplan to help better identify system priorities as well as how the network hopes to improve outcomes. To help improve resident outcomes who have worsening ulcers, the Waterloo Wellington Integrated Wound Care Program will partner with the Long-Term Care working group for ulcers which will be supported and provided with networking, best practice guidelines and resources.

LHIN staff have also been working with system partners to develop a capacity plan for Long-Term Care (including short-stay beds, convalescent care, and supporting programs).

OUR PRIORITY: LEADING A QUALITY HEALTH CARE SYSTEM USING EVIDENCE-BASED PRACTICE

Improve patient outcomes through the delivery of best practice care, at the best practice price, in alignment with province-wide Quality Based Procedures (QBPs).

The implementation of clinical order sets has been identified as a key tool in the delivery of standardized, best-practice care by promoting and/or enabling:

1. Accelerated adoption of evidence-based best practices (e.g., QBP clinical handbooks);
2. Improved quality of care and patient outcomes and safety, and reduction in the risk of errors;
3. Identification of and reduction in variation in defined best-practice (e.g., QBP clinical handbooks);
4. Better informed clinical decision making, and improved work-flow standardization including order entry at the point of care; and,
5. Increased efficiency through the adherence to best-practice care at the QBP price.

In the past quarter, a presentation has been made to SMGH/GRH Medical Advisory Committee about the clinical order sets. The kick off meeting was held for the regional project team with the vendor and a gap analysis is underway for each of the order sets. Next steps will include determining the first round of order sets for implementation.

Expand and enhance integrated programs that ensure quality and deliver best practice care across the continuum of care. Key improvements will include:

Cardiac:

SMGH Arrhythmia Program Risk

The proposed arrhythmia program at SMGH to enhance cardiac care services within the LHIN has been delayed with additional detailed requirements to their proposal requested by the cardiac care network. These delays have resulted in the loss of a recruited electrophysiologist to another LHIN as the physician hired by SMGH was unable to sustain his level of required training in his area of specialty. The resulting loss and the integration of pacemaker services within the LHIN has created a situation whereby the Waterloo Wellington LHIN currently has only one specialist physician to implant pacemakers and cardioverter defibrillators. SMGH is awaiting a response from the CCN regarding recommendations from their arrhythmia program proposal. Once received, SMGH will work with the LHIN to review the proposal and associated capital planning needs in order to move this program forward.

Implement the provincial life or limb policy across Waterloo Wellington: The Life or Limb policy is now fully implemented in Waterloo Wellington LHIN. In reflecting upon its implementation, additional work has been identified by the Critical Care Council related to data integrity and process improvement to ensure we are using the data available fully in system planning. These opportunities are carrying forward and collaboration with Critical Care Ontario to both improve our data quality and refine the provincial dataset to better serve hospital operations are embedded in the Critical Care Council work-plan going forward.

Implement critical care High Performing Checklist:

The Critical Care Council has identified specific quality improvement initiatives for next year, substantially supported through our investment in Patient Order Sets. These take our quality improvement work beyond the High Performing Checklist and focus on priority areas for improvement locally in consultation with physicians, administrative and other front line clinical staff. The local framework allows the flexibility for each hospital to select how they will approach the suite of initiatives while building on the implementation experience of their peers, with an end-goal to have all institutions working to a single standard of care by year end across all initiatives.

Emergency Department (ED)

Implement best practices across the continuum of care to meet emergency department wait times:

ED Pay for Results (P4R) planning for 2015/16 is underway. Action plans from local hospitals have been reviewed and approved by the LHIN ED Physician Lead and LHIN staff, and they have been submitted to the Ministry. The P4R program is intended to support patient flow throughout the hospital. Initiatives identified by hospitals that would help patient flow must demonstrate that they will have a positive impact on reducing ED lengths of stay.

As fiscal year 2014/15 approaches an end, projecting Waterloo Wellington LHIN performance against meeting accountability targets is becoming clearer. For ED lengths of stay metrics, year-to-date data is available from April 2014 to January 2015, inclusive.

ER Length of Stay for Admitted Patients: The Waterloo Wellington LHIN will not meet the local target of 8 hours in 2014/15. WWLHIN has had the best performance in Ontario on this metric for the past 24 consecutive months and is 7 hours better than the next best LHIN (16.7 hours vs. ESC LHIN at 23.7 hours). Ontario has set an interim 25 hour target for this metric and the Waterloo Wellington LHIN is one of only 3 LHINs that is meeting this target thus far in 2014/15.

ER Length of Stay for Non-Admitted High Acuity Patients: The Waterloo Wellington LHIN will meet the 7 hour local target in 2014/15. Of note, the Waterloo Wellington LHIN has met this target for the past 18 consecutive months.

*ER Length of Stay for Non-Admitted Low Acuity Patients: W*ith continued improvements in Q4, it is possible that the Waterloo Wellington LHINwill meet the 4 hour target. Thus far in 2014/15 (April 2014 – January 2015), the Waterloo Wellington LHIN performance is at 4.2 hours which is 0.1 hours better than last year. The 4.2 hour result is projecting to be the best-ever fiscal year result achieved in Waterloo Wellington. Measures have been taken to improve this metric (see 'Implement best practices for patient triage').

Implement best practices for patient triage:

To foster continual improvement, the Waterloo Wellington LHIN funded GGH as the sponsor organization of the Integrated ED Council to organize a conference focusing on best practices in pre-triage that focuses on improving care for patients before they are seen by an ED physician. This conference was held on January 13, 2015 and provided a forum where local clinical and administrative leaders collaborated and shared best practices while hearing from leading organizations in Ontario on the strategies they used to improve care early in the patient's ED journey. Hospitals presented their improvement plans stemming from this event at the Integrated ED Council meeting on March 10, 2015. Improving the triage process will help to reduce the ED length of stay for all patients.

Hospice Palliative Care

The Integrated Hospice and Palliative Care Council (IHPC) is moving into year three of its three year work plan. Through the engagement of an independent facilitator, the Integrated Program is conducting a review and refresh of its work plan to ensure alignment with local, system and provincial priorities. This facilitator has guided the Council through a review of their accomplishments to-date, and prioritized hospice palliative care work for the system for the next few years. To facilitate the validation and communication with community stakeholders, the Council engaged with stakeholders in January to share findings and gather input.

Improve admission process: As part of the 2014/15 work plan, the IHPC Council will continue to look for ways to improve admission processes to hospice services.

Improve service delivery model to support clients at home: At the end of Q3, the eShift program was operational in the LHIN for about 9 months. eShift has enabled over 50 more residents to die in their place of choice – in this case home – with the support of specially trained palliative care PSW's, who through technology are connected to and supported by a single shift nurse. The eShift program currently has capacity to support up to 8 residents at once. We are currently investigating ways to further enhance the service delivery model to support more clients at home and in their place of choice.

Mental Health and Addictions

The additional investments in community-based care, specific to areas of system pressures including services to complex residents via ACT (Assertive Community Treatment) team step-down, extraordinary needs and eating disorders counseling, will no doubt assist in providing more residents access to needed services and

care. The Integrated Mental Health and Addictions Program Council continues to monitor the system impact of these and other system changes towards system improvements. Specifically, there is close attention being paid to reasons why the repeat ED visits for substance abuse seems to rise every 2nd quarter (trending over 4 years).

The Mental Health and Addictions Program Council has also endorsed and recommends all service providers adopt the "Welcome Initiative" – a quality improvement process that ensures that every service provider is welcoming, and complex-capable to meet the diverse needs of residents. Service providers are individually, and as a system, understanding ways to measure this quality improvement and ways to demonstrate progress to residents and stakeholders.

Waterloo Wellington LHIN is participating on the Children & Youth Lead Agency Advisory Committee. Lutherwood is the Lead Agency for Waterloo Region. We have recently completed a draft plan for system change priorities and key activities which will be submitted to the Ministry. This plan connects nicely with the work in the broader mental health and addictions system.

Rehabilitative Care

Implement standardized patient pathways across sites:

Acquired Brain Injury is an identified fifth stream of rehabilitation in Waterloo Wellington LHIN. Over the past two months, Karen Conway (Grand River Hospital) and the ABI steering committee have worked to inventory current services, formulate care pathways and identify best practices for admissions, transitions and care of individuals with an ABI. The work is intended to result in a fully coordinated and seamless health care experience for those who have survived a brain injury from the point of acute injury through to rehabilitative care in the community. A report with recommendations is expected to be submitted to the Waterloo Wellington LHIN in April 2015.

The WWCCAC hosted a meeting in January 2015 to bring together care partners in community rehabilitation services with a purpose of identifying opportunities for improvement and barriers to change in the service delivery model. The meeting allowed open communication that will aid the group in identifying next steps.

Surgery

Design and implement an integrated access system for orthopedic surgery:

The current Performance Dashboard shows that in Q3, the Waterloo Wellington LHIN as a system did not meet target for priority 4 hip replacement surgery (89%) or knee replacement surgery (85%). There is strong indication, however, that targets will be met in Q4. For priority 4 surgeries that took place between December 2014 and February 2015, 96-100% of hip replacements and 96-98% of knee replacements were completed within the 182 day access target.

It has been written previously that the Waterloo Wellington LHIN performance had been strongly negatively affected by one high-wait surgeon at CMH. Senior administrative and clinical staff at CMH have been engaged and the Waterloo Wellington LHIN Health System Decision Support Centre worked with the surgeon's office to improve record management processes. In a short time, their efforts are showing to be effective as his/her performance is steadily improving. The most

current data thus far in Q4 (January and February 2015) shows that this surgeon completed 100% of priority 4 knee replacements within target and 93% of priority 4 knee replacements within target (n=30); at the time of engagement in Q1, the high-wait surgeon completed just 9% of priority 4 knee replacement surgeries within target.

In Q3, the Waterloo Wellington LHIN funded CMH to provide primary care and patients with surgeon-level wait time information for orthopaedic surgery. This initiative aligns the Minister's Patients First: Action Plan for Health Care by supporting residents in being active partners with their family physicians by having relevant information to make informed decisions about their health care options. The hospital is to conduct an evaluative analysis of the adoption, use and results of this initiative (currently in use at GGH and CMH) and its impact on patient care and engagement and report back to the LHIN by March 31, 2015. Further, the evaluative report will address the value of spreading this initiative across Waterloo Wellington and the resources required to do so in a sustainable way.

Develop and implement the Waterloo Wellington Vision Plan including possible community-based specialty clinics: In 2012, the Ministry of Health and Long Term Care (MOH) requested that a Provincial Vision Strategy Task Force conduct a thorough review of current services and future needs for Ophthalmology in Ontario. The Task Force developed a list of recommendations to improve access, quality and appropriateness of services, performance management and accountability, and system planning. A fundamental recommendation was that each LHIN develop a Local Vision Plan describing how they will provide for the current and future needs of their communities. In the spring of 2014, the Integrated Surgical Program Council pulled together a local Vision Care planning group to develop the plan; its membership included ophthalmologists from each surgical eye care site, an anesthesiologist, chief of surgery, local optometrists, School of Optometry and Vision, hospital administrators and LHIN staff. The Waterloo Wellington Local Vision Plan is now complete and has been presented back to the Surgical Program Council. It is anticipated that the final plan will be submitted to the Waterloo Wellington LHIN in late March. Following the review of the Local Vision Plan by the LHIN, the plan will be submitted to the ministry.

Implement new integrated programs which will include the establishment of a program sponsor and clinical councils for each program, identification of standards and care pathways and a move towards more equitable access and consistency of quality across Waterloo Wellington:

Integrated Diagnostic Imaging Program: The Integrated Diagnostic Imaging Council is currently in the process of building a two year Programmatic Strategic Plan for medical imaging. This has been supported through one-time investment in Q3, used to engage a team of program design experts as well as a Radiologists to look at the landscape in Waterloo Wellington in order to provide better patient outcomes through delivery of a single standard of high quality of care, improved information management and its impact on the patient experience and opportunities for better integrating our technology infrastructure.

Integrated Wound Program: The Integrated Wound Care Program convened in January 2014 with a goal to improve clinical outcomes including decreasing the prevalence of avoidable wounds and to provide better value per health care dollars for the residents of Waterloo Wellington.

Significant work continues within the program; the Clinical Practice and Knowledge Translation Collaborative continues to meet on a bi-weekly basis; this group is working on the 2nd of nine priority areas in alignment with an etiology-based work plan.

This quarter, the Regional Program website and features the integration of clinical content in alignment with the work plan of the Clinical Practice and Knowledge Translation Collaborative; please visit http://wwwoundcare.ca/ for more information.

Also in Q3, the Program conducted a survey to better understand the needs of health care providers in terms of resources, materials and education for the regional program. Over 100 respondents from across the continuum including physicians, nurse practitioners, personal support workers, dietitians, social workers, registered nurses, registered practice nurses, care coordinators and ETs indicated that the top 3 areas of interest were 1) wound treatment and management 2) wound prevention and 3) wound assessment and identification. Survey results also indicated that the top three priorities based on etiology were 1) pressure ulcers 2) diabetic foot ulcers and 3) venous leg ulcers.

ATTACHMENT B:
ACTION PLANS – INITIATIVES UPDATE

ACTION PLANS

ENHANCING YOUR ACCESS TO PRIMARY CARE	2015/16		2016/17		2017/18	
	Progress	% Complete	Progress	% Complete	Progress	% Complete
Build on the four Waterloo Wellington Health Links to improve coordinated access to care for residents with complex conditions.	In Progress	70	In Progress	80	In Progress	100
Ensure residents with complex conditions have access to primary care.	In Progress	80	In Progress	90	In Progress	100
Continue to grow partnerships amongst and between health, housing, social services, education, justice and other community partners to improve population health.	In Progress	75	In Progress	90	In Progress	100
Identify more effective support for those at risk in our community through efforts such as Connectivity/Situation Tables.	In Progress	75	In Progress	100	In Progress	
Build, enhance and sustain coordinated access to services through the System Coordinated Access project which includes access to Community Support Services, Rehabilitative Care, Palliative/End of Life Care, Mental Health and Addictions services, Diabetes Education and others.	In Progress	90	In Progress	100		
Support primary care in ensuring coordinated, equitable, informed access to specialist care and explore options for shared care planning.	In Progress	25	In Progress	50	In Progress	75
Review and optimize use of telemedicine and telehomecare.	In Progress	50	In Progress	75	In Progress	100
Improve access and best practice guidelines for diabetes care and chronic disease prevention and management focused on congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).	In Progress	75	In Progress	90	In Progress	100
Improve access to appropriate levels of heart failure care in community, primary and acute care settings.	In Progress	40	In Progress	70	In Progress	100

CREATING A MORE SEAMLESS AND COORDINATED HEALTH CARE EXPERIENCE	2015-2016		2016-2017		2017-2018	
	Progress	% Complete	Progress	% Complete	Progress	% Complete
Establish efficient and integrated personal support service delivery for residents in the community.	In Progress	80	In Progress	100		
Improve health outcomes and experience for residents by increasing timely access to equitable and integrated community services.	In Progress	50	In Progress	90	In Progress	100
Continue to improve care for seniors through effective assess and restore services, dementia and Alzheimer strategies and improving access to specialized geriatric services.	In Progress	75	In Progress	90	In Progress	100
Improve patient experience and flow by integrated discharge and patient transition practices, including patients with mental health conditions and addictions from hospital.	In Progress	50	In Progress	75	In Progress	100
Remove barriers for people waiting for an alternate level of care (ALC).	In Progress	60	In Progress	75	In Progress	100
LEADING A QUALITY HEALTH CARE SYSTEM USING EVIDENCE-BASED PRACTICE	**2015-2015**		**2016-2017**		**2017-2018**	
	Progress	**% Complete**	**Progress**	**% Complete**	**Progress**	**% Complete**
Quality Improvement o Accelerate best practice care through the system-wide adoption of electronic clinical order sets for Quality Based Procedures. o Enhance quality and ensure delivery of best practice through current integrated programs and implement new integrated programs.	In Progress	75	In Progress	90	In Progress	100
Palliative Care o Improve the end-of-life experience for palliative residents and their families by ensuring options for people to die in the place of their choice. o Support advance care planning processes across the continuum of care and through-out the community.	In Progress	50	In Progress	75	In Progress	100
Long Term Care o Improve the quality and safety of care in Long-Term Care Homes.	In Progress	50	In Progress	75	In Progress	100

Emergency Department o Continue implementation of best-practices in Emergency Department care. o Improve care and experience for mental health and addictions patients.	In Progress	75	In Progress	100		
Surgery o Improve access to specialized vision (eye) care and promote seamless eye care experience by strengthening the relationships between primary care, ophthalmology and optometry.	In Progress	75	In Progress	100		
Mental Health and Addictions o Ensure all residents have access to complexity capable services at the right time, in the right place. o Improve access to intensive mental health services including optimizing Assertive Community Treatment Teams and support coordination. o Expand availability of mental health and addiction supports in housing.	In Progress	75	In Progress	100		
Diagnostic Imaging o Reduce duplicate diagnostic imaging procedures. o Reduce wait times for diagnostic imaging procedures by optimizing service delivery models.	In Progress	50	In Progress	75	In Progress	100
Critical Care o Implement standardized clinical protocols and ICU best-practice design. o Develop and implement long-term ventilation program standards.	In Progress	80	In Progress	100		
Pharmacy o Implement protocols for anti-microbial stewardship	In Progress	80	In Progress	100		

Waterloo Wellington Local Health Integration Network

50 Sportsworld Crossing Road, East Building, Suite 220, Kitchener, Ontario N2P 0A4
Local: 519-650-4472
Toll-Free: 1-866-306-LHIN (5446)
Fax: 519-650-3155
Website: wwlhin.on.ca Email: waterloowellington@lhins.on.ca