Waterloo Wellington **LHIN**

Annual Business Plan

2016-17




Ontario
Local Health Integration Network

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Waterloo Wellington Local Health Integration Network

The Waterloo Wellington Local Health Integration Network (Waterloo Wellington LHIN) is responsible for designing, funding and overseeing the performance of the health system for the almost 800,000 people who live in Waterloo Region, the City of Guelph, Wellington County and the southern part of Grey County.

We work with residents, families, health service providers, community organizations, local government and other community partners to build a better health care system for everyone in Waterloo Wellington. We are passionate about putting residents first in everything we do.

We listen, we build partnerships, we act, and we lead, and we do it all *together* with dedicated health care professionals across the system.

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.

We are led by a Board of Directors, made up of local residents, that sets our strategic direction and makes decisions to meet our residents' changing needs.

Our team is comprised of physicians, nurses, social workers and other health care and business professionals dedicated to putting residents first and supporting better health and well-being for all.

2016/17 Annual Business Plan

This document provides an overview of the plan to improve the local health system for Waterloo Wellington LHIN residents in 2016-17. The plan supports the 2016-19 Integrated Health Service Plan which was created as a direct response to the needs and experiences of local residents, health service providers, front-line staff and other community partners. It's not our plan – it's everyone'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 of everyone in Waterloo Wellington.

Bruce Lauckner, CEO

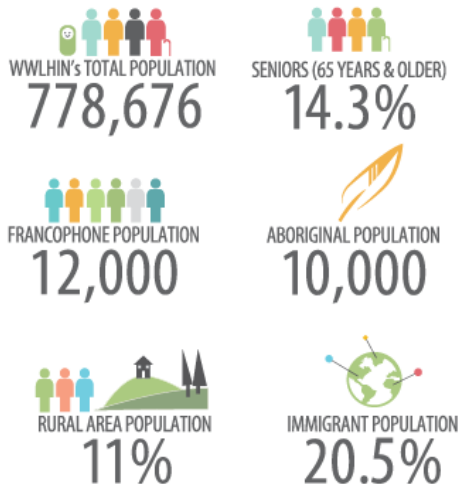
Joan Fisk, Board Chair

Our Population

With a population of almost 800,000, the Waterloo Wellington LHIN is a growing community of diverse residents. Our population is projected to grow to over 860,000 residents by 2025. Seniors 65 and over make up more than 14% of the Waterloo Wellington LHIN population, with those 75 and over accounting for over 6%.

No one knows better what is needed for our community than the residents who live here, work here and receive health care here. We interact regularly with our residents through various engagements to seek input and feedback on what is working well in the health system and where there is opportunity for improvement. That is the benefit of being local: knowing our residents' needs, understanding the health system and where pieces need to be better connected and leading locally driven solutions to improve the health of the entire population.

Our geography includes four sub-regions areas that we have identified based on where people go to receive health care services: Wellington, Guelph, Cambridge North Dumfries and KW4 (Kitchener-Waterloo, Wellesley, Woolwich and Wilmot). Understanding the four sub-regions helps us to plan care for our residents close to home.



In our LHIN, 20.5% of the population is made up of immigrants. The Waterloo Wellington LHIN is one of the key landing sites for refugees in Ontario. Nearly 14% of our residents are visible minorities. 10,000 of our residents self-identify as Aboriginal. Just over 12,000 residents are part of the Francophone community. More than 20% of residents report a mother tongue other than English or French.

Meeting the Needs of Our Diverse Residents

Diversity is part of what makes Waterloo Wellington unique. As we move forward with the plan for system improvement, we will be especially focused on the overall health of our population and inequities in our system.

Not all people have the same starting point when it comes to health.

Those who are most vulnerable, marginalized, and who experience barriers within the system may have equal access but they don't have the same outcomes because of a variety of factors including social determinants of health like income, education, employment and access to nutritious food.

Our vision is for **all** of our residents to have better health and a better future.

Health Care in Ontario

In early 2015, the Ministry of Health and Long-Term Care released *Patients First: Ontario's Action Plan for Health Care* (Patients First). It is Ontario's plan for changing and improving the health system across Ontario. It is built on the foundation of making the needs of patients and their families the focus of our health system.

Putting Patients First Means

- Supporting Ontarians to make healthier choices and help prevent disease and illness.
- Engaging Ontarians, 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 they need it.
- Making decisions with patients, so the patients play a major role in affecting system change.
- Being more transparent in health care, so Ontarians can make informed choices.

Patients First highlights the importance of improving the patient experience. It demonstrates a commitment to health equity, access and universality – simply put, ensuring high-quality health care for everyone. *Patient's First* outlines four priorities for improvement of the health system in Ontario.

ACCESS - Providing faster access to the right care.

CONNECT - Delivering better coordinated and integrated care in the community, closer to home.

INFORM - Support people and patients – providing the education, information and transparency Ontarians need to make the right decisions about their health.

PROTECT - Protect our universal public health care system – making evidence based decisions on value and quality, to sustain the system for generations to come.

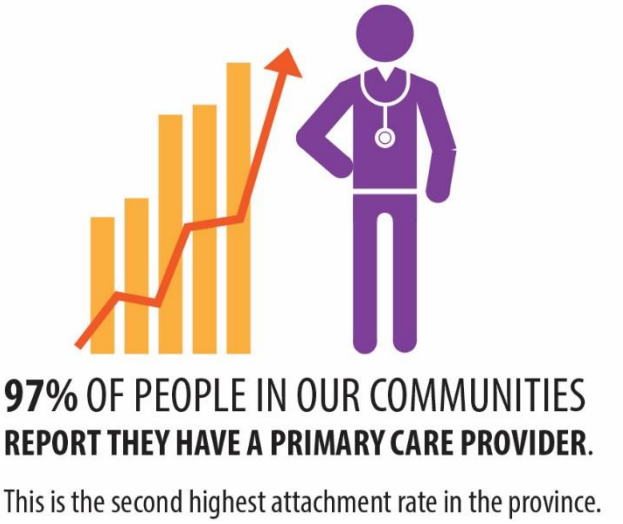
In December 2015, the Ministry released a proposal for the next phase of the Patients First plan. P*atients First: A Proposal To Strengthen Patient Centered Health Care In Ontario* outlines a series of recommendations and highlights a need for the LHINs and health service providers to continue working together to improve the health system and address gaps in care. Part of the paper includes a plan that will see Ontario LHINs take a bigger role in providing direct care, strengthening relationships and accountability between primary care and public health, and a focus on population health, further integration of services and partnerships.

Strong Local Health System that Keeps Improving

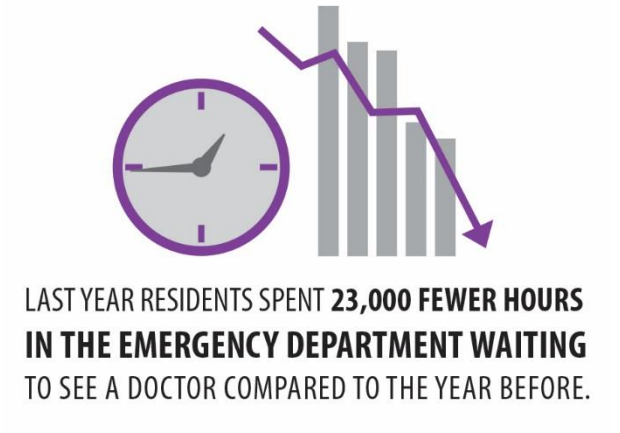
Progress on the 2015/16 Annual Business Plan

2015-16 was the final year of the 2013-16 Integrated Health Service Plan (IHSP). It was an opportunity to further develop key partnerships and implement key initiatives that have improved the health and well-being of our residents and set the stage for the important work that needs to be done over the next several years. Highlights of progress made through implementing the 2015-16 Annual Business Plan include:

- **34,000 telemedicine events in Waterloo Wellington in 2015-16**. This means residents who have difficulty traveling to see their doctor received care over secure video conferencing.
- **Nearly 950 residents with complex needs received a coordinated care plan through Health Links in 2015-16**. People with complex health and social needs can have as many as 15 different care providers without a coordinated approach.
    - **Adult day programs in the region expanded to provide service to more than 1,600 seniors last year.** Many residents rely on community day programs to support seniors' with physical or cognitive disabilities and/or mental health concerns.



- **More than 4,000 health care staff can access electronic health records in Waterloo Wellington.** Without information sharing between care providers many residents have to repeat their story. This can get in the way of getting the right care. With the use of electronic health records growing among care providers, residents receive safer and more effective care.
- Improvements in patient flow, including additional investments in home care, meant our residents spent nearly **500 fewer days in hospital between April and September 2015** compared to the year before.



- A **57% increase in the number of long-term care beds in the City of Waterloo** through the opening of The Village at University Gates.[1]
- Reduced wait times for patients seeking help for a mental health or addictions crisis in Guelph.
- The Ontario Stroke Network recognized Waterloo Wellington as having the **most improved stroke program in the province.**
- **More than 327 health service providers now receive electronic summary reports through Hospital Report Manager (HRM).** When people go to the hospital, their family doctor or nurse practitioner automatically receives updated information about their hospital visit in their electronic medical record. This helps primary care providers deliver better overall follow-up care post discharge.
- Guelph General Hospital (GGH) ranked **3rd best performing hospital in the Emergency Department Pay for Results (ED P4R) program** in 2015-16 out of the 73 hospitals participating in the program. As a result, GGH earned nearly $2M to help fund initiatives next year aimed at improving patient flow and patient satisfaction.[2]

"I'm so proud to live in a country that has programs like the stroke program. I've been the beneficiary of so much support, and I don't know where we'd be without it."

Local Resident

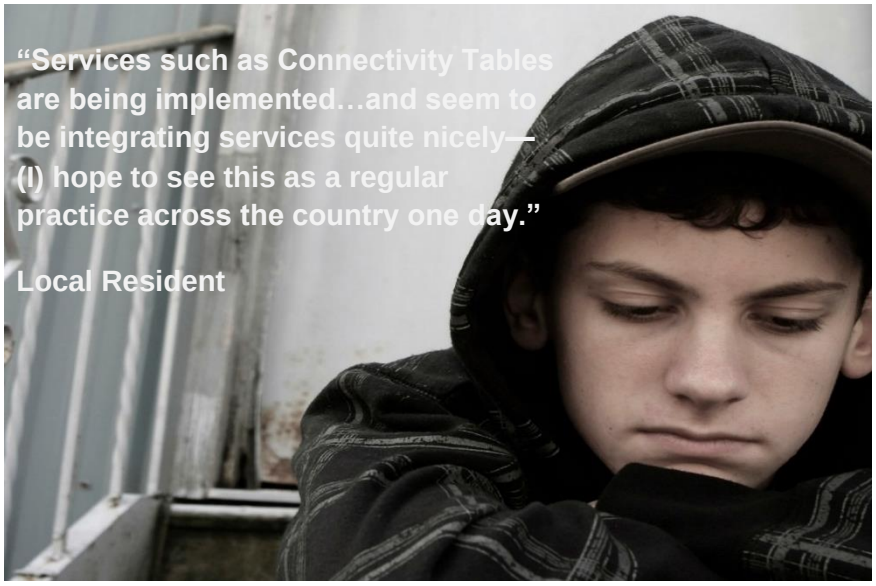
- Some of the most effective hospitals in Ontario. **Our rate of readmissions to hospital for surgical patients is the lowest in the province.[3]**
- **Over 2,800 residents have received advance care planning resources** through Advance Care Planning Waterloo Wellington. An Advanced Care Plan (ACP) is a plan that provides the resident, their family and caregivers an opportunity to consider what medical and social care

[1] Health Data Branch, MOHLTC. (2015). WWLHIN and Long-Term Care Home System Report.
[2] Access to Care Analytics. (February 1, 2016). ER P4R Ranking Report 201512. Cancer Care Ontario.
[3] Canadian Institute for Health Information. (2015). Your Health System: Surgical Patients Readmitted to Hospital details for Waterloo Wellington LHIN. Retrieved from http://yourhealthsystem.cihi.ca/hsp/indepth#/indicator/028/3/C5004/

they would prefer, or refuse, during a time of crisis or end-of-life. This plan is more than a single document; it is a holistic view of the needs and wishes of a person during end-of-life care.

- Some of the safest hospitals in Ontario. **Grand River Hospital ranks among the top ten safest hospitals in Canada** for patient mortality. Our rate of hospital standardized mortality ratio is the second lowest in the province.[4]
- Mobile crisis teams partner a psychiatric nurse with police to provide a coordinated response to mental health crises in the community. **Mobile crisis nurses have assisted police with 842 situations.**[5]

Connectivity Tables – The international award-winning partnership between Langs Community Health Centre and the Waterloo Regional Police Service brought wrap-around social services to over 300 residents in 2015.



[4] Canadian Institute for Health Information. (2015). Your Health System: Hospital Deaths (HSMR) details for Waterloo Wellington LHIN. Retrieved from http://yourhealthsystem.cihi.ca/hsp/indepth#/indicator/005/3/C5004/.
[5] Sheppard, D. (February, 2016). The Specialized Crisis Nurse Program: An Alternate Model of Mental Health Crisis Response. Retrieved from National Police Federation, Blue Line Magazine. http://www.blueline.ca/articles/the_specialized_crisis_nurse_program.

Health System Improvement for 2016-17

While these pockets of excellence are outstanding achievements, we know there is still much work to be done in other areas. We asked residents to tell us what truly mattered to them, and in response, identified key areas of focus for the next year. The Annual Business Plan outlines the specific initiatives the Waterloo Wellington LHIN will undertake alongside local health service providers to make progress in these areas. These initiatives will be system wide priorities over the next year and will help to ensure better health and better futures for everyone in Waterloo Wellington.

The Waterloo Wellington LHIN and our health service providers also have specific obligations related to the health and well-being of our Francophone and Aboriginal residents. Our Annual Business Plan begins with the actions we will undertake to continue improvements in these areas.

Francophone Residents

Francophone residents have unique needs and challenges in navigating the health system. We have enhanced access to care for Francophone residents, including hosting a French–language health care forum designed to ease navigation of the health system. In the coming year, we will build on successes to date and continue our partnership with the French Language Health Planning Entity (Entity^2) to understand and support the health needs of Francophone residents. The French Language Service Plan for 2016-17 focuses on enhancing health equity for our Francophone residents and improving access to mental health and addictions services, primary care and home and community care services for seniors in French.

In 2015-16, the French Language Service Report, submitted annually by all health service providers to the Waterloo Wellington LHIN, was expanded to include specific questions on health equity. Working in partnership with the Entity^2, we will use the data collected to develop a community engagement plan that will help us to ensure more equitable access to health services for Francophone residents. As a non-designated area, the WWLHIN is currently meeting all of its obligations under the *French Language Services Act (FLSA)* and continues to go above and beyond to better serve French-speaking residents.

In 2016-17, we will continue to improve access to culturally and linguistically appropriate care for our Francophone residents. With our health service providers, we will explore ways to provide access to mental health services through the use of enabling technologies. Mental health support

in Waterloo Wellington has already been expanded for Francophone residents through counselling delivered over secure video conferencing. We will conduct an inventory of the languages spoken by primary care providers in each of the sub-region areas to ensure gaps are identified. Timely access to primary care for Francophone residents will be supported through partnering with Health Force Ontario to encourage French-speaking primary care providers to locate in Waterloo Wellington.

Francophone seniors in the community face difficulties in accessing programs that meet their needs. To address this barrier, we have expanded supports for Francophone seniors in our community by offering French-language seniors' exercise programs. Over the next year, the Entity[2]'s community engagement plan will gather additional information on the needs of Francophone seniors. This will help us to better understand their needs so we can work with our health service providers to further adjust or realign home and community care programs.

Aboriginal Residents

We work closely with our local Aboriginal communities to identify and address gaps in health services. Improvements are advanced through the work of our Aboriginal Health and Wellness Promoter, who is funded to help Aboriginal residents navigate health services in Waterloo Wellington. In the coming year, we will work with the Aboriginal community to build local access to traditional and culturally sensitive services.

We will continue to ensure health service providers receive Aboriginal cultural safety training and maintain a focus on mental health and addictions services, chronic disease prevention and management, as well as palliative and end-of-life care.

In 2015-16, cultural safety training was focused toward health service providers working in mental health and addictions. This training helps to ensure health service providers have the knowledge and tools they need to provide culturally safe services for our Aboriginal residents. We plan to continue to provide Aboriginal cultural safety training for health service providers in Waterloo Wellington over the next three years.

In 2015-16 the Waterloo Wellington LHIN initiated a mental health, addictions and homelessness solution table, including representation from the Aboriginal community, health service providers and social service stakeholders. We will continue cross-sector collaboration to identify innovative ways to address the complex issues of mental health, addictions, and homelessness in the Aboriginal community.

Aboriginal residents have higher rates of certain chronic diseases. Knowing this, we have implemented specific chronic disease prevention and management programs to meet the needs of our Aboriginal residents, including an Aboriginal diabetes education program that incorporates traditional healing practices. In 2016-17, we will continue to focus on improving chronic disease prevention and management services for Aboriginal residents.

Aboriginal residents have an end-of-life process that is not always reflected in mainstream hospice and palliative care services. Hospice services, based on the culturally specific needs of Aboriginal residents, are now available in Waterloo Wellington. A number of our health service providers now have specific facilities where Aboriginal ceremonies, conducted around end-of-life, can take place. We will continue to safeguard appropriate end-of-life care for our Aboriginal residents by ensuring there is appropriate Aboriginal representation on the Hospice Palliative Care Network in Waterloo Wellington.

As the provincial government continues to work with Aboriginal leaders on the implementation of the Accord, the Waterloo Wellington LHIN will ensure that provincial directions are implemented locally and will work with our local Aboriginal communities to ensure the unique needs of our residents are considered.

Focus Areas for 2016-17

The Annual Plan delivers on the priorities and objectives outlined in the 2016-19 IHSP. In each of the three years of the IHSP, the LHIN and health service providers focus in on key initiatives to achieve results. To zero in on where to start, we asked our community what was most important to them.

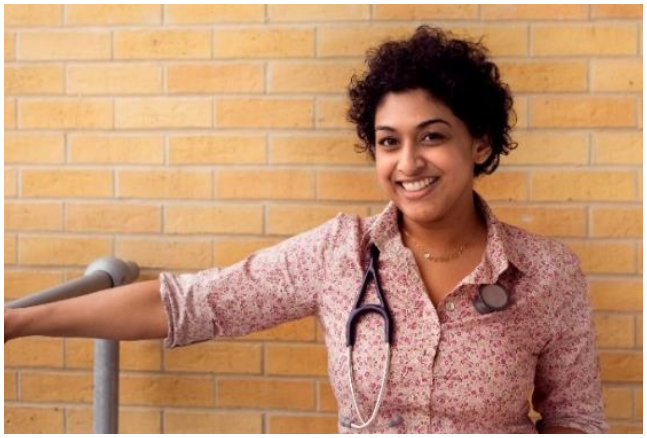
Residents tell us there are lots of good things about the care they receive locally - improved access to quality specialized care such as cancer care and stroke services, centralized access to mental health supports and diabetes services for example. They also tell us the next focus areas for improvement are timely access to quality care in the community – focusing on primary care and homecare. Perhaps not surprisingly, that's what front-line professionals tell us too.

In 2016/17, there will be specific focus on three main areas in our work:

- **timely access to primary care,**
- **improving the home care experience, and**
- **continued focus on quality.**

97% of residents in Waterloo Wellington report having a primary care provider; however their experience accessing primary care is not always the same.

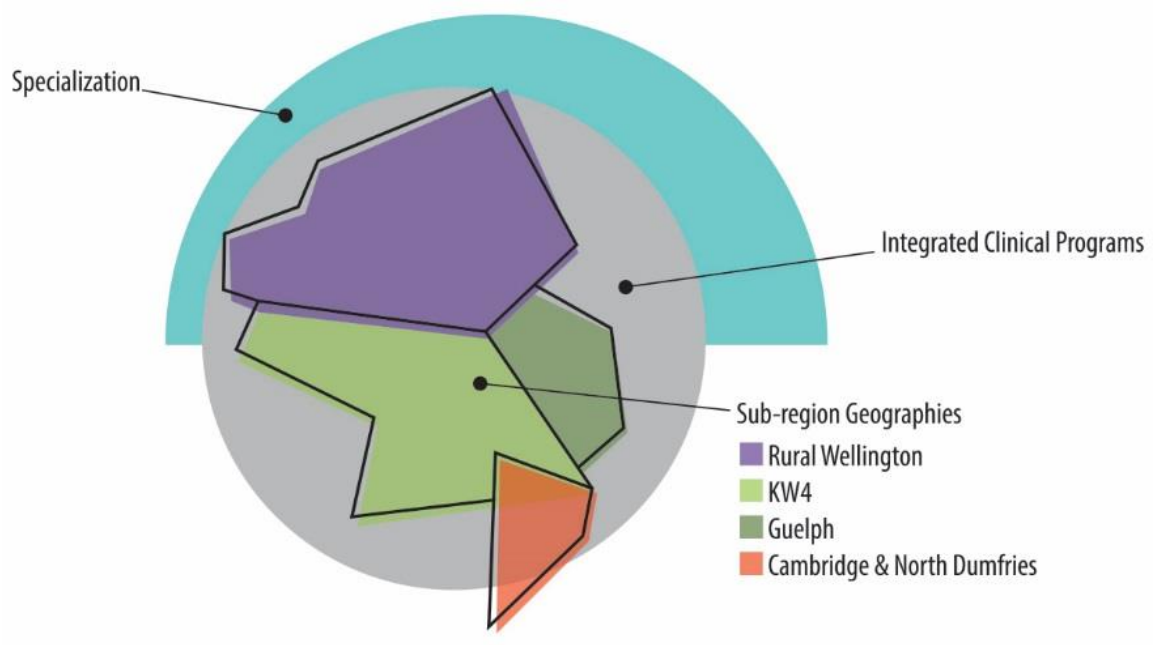
Some residents in Waterloo Wellington are able to get same or next day appointments or see a primary care provider in the evening or on weekends. Others do not have this access and need to wait longer or go to the emergency department for care.



To support improvements in access to care, we will engage primary care providers to identify and lead the implementation of system improvements. These improvements will be tailored to the specific needs of each community because we know the patient experience and local resources are different in different areas.

Waterloo Wellington Sub-regions

Over the next year, we will develop and work with existing sub-region tables, including physicians, residents, governors and other local leaders. These groups will work together to identify and act on common areas of focus for ensuring residents within each sub-region area have access to high quality, coordinated care. The sub-region areas are Wellington, Guelph, Cambridge & North Dumfries, and KW4 (Kitchener-Waterloo, Wellesley, Woolwich and Wilmot).

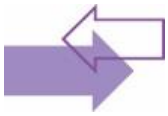


At the same time, we have heard from primary care providers that there are some specific areas we can act on to improve care immediately while establishing the sub-region work that will support them in improving same day/next day and afterhours access.

When we asked primary care providers “How can we help you help your patients?” we got a clear answer - help us make closer connections with the rest of the system. They highlighted the opportunity to better integrate the work of the Community Care Access Centre and other health service providers with primary care. They told us they need specific help related to care coordination for patients with complex conditions, system navigation and equitable access to homecare services.

In 2016-17, we will support our primary care providers in treating patients with multiple conditions by increasing the use of coordinated care plans in Health Links. We will expand the use of technology solutions, such as notifications when patients are discharged from hospital and e-consults with specialists. We will also work with health service providers to ensure more equitable access to interdisciplinary teams for all primary care practices, and expand on the experience in Family Health Teams and Community Health Centres by using existing resources in more coordinated ways.

A summary of specific initiatives is outlined in the table below.



ACCESS – PROVIDING FASTER ACCESS TO THE RIGHT CARE

IHSP 2016/19	Plan for 2016/17	This will Result In
Ensure timely, accessible, supportive primary health care for all, including enhancing access for specific populations	• Engage primary care providers to identify and lead implementation of system improvements in local communities which result in more residents having a primary care provider and better access to after hours and same/next day appointments. • Improve coordinated care for residents with complex conditions using Health Links – partnering them with a care provider who knows them and is familiar with their situation.	• Improved access to primary care when needed. (decreased emergency department visits for non-emergency needs). • More residents with complex needs having individualized coordinated care plans.
Provide seamless, high quality service delivery in the four sub-regions	• Create a seamless, coordinated experience for patients discharged to community from all Waterloo Wellington hospitals, including communication between primary care and community based care. • Develop sub-region integrated care tables with physician leadership, patient involvement and local leaders that identify and ensure	• More seamless experience of care in local communities.

	residents get access to care, closer to home. • Improve access to specialist care through centralized access.	• Residents being able to self-navigate the local health system. • Decreased wait times to see specialists (Wait 1).
Improve access to timely mental health and addictions services	• Improve mental health and addictions services based on needs of patients, including adult intensive services and centralized access. • Expand options for residents needing mental health and/or addiction crisis supports outside of the emergency department.	• Increased satisfaction and reduced wait times for mental health supports. • Fewer residents having to return to the emergency department for mental health and/or substance abuse conditions.
Transform palliative and end-of-life care	• Support residents, providers, and caregivers in planning for end-of-life through access to resources and supports. • Improve access to care teams to support patients' comfort measures at end-of-life. • Enhance community care and pain management options to reduce unnecessary deaths in hospital.	• More residents, caregivers, health service providers, and others will have information on planning for end-of-life. • Palliative care patients being discharged from hospital with home support.

CONNECT - DELIVERING BETTER COORDINATED AND INTEGRATED CARE IN THE COMMUNITY, CLOSER TO HOME.

IHSP 2016/19	Plan for 2016/17	This will Result In
Integrate hospital care to deliver consistent, evidence-based best practice as a specialized resource on the health journey	• Ensure emergency department, surgical and diagnostic wait times meet the quality standard.	• Residents receiving timely access to non-emergency hip and knee replacements. • Residents who arrive at the emergency department with complex needs being seen and sent home or transferred to a hospital bed in 8 hours or less. • Residents with minor uncomplicated needs requiring care in an emergency department being seen and sent home in 4 hours or less. • Residents receiving timely access to non-emergency MRIs and CT scans.
Strengthen home and community care	• Dramatically improve the patient experience in home and community care through implementing the 10 recommendations from the Patients First Home and Community Care Roadmap.	• Residents with complex needs waiting no more than 5 days for in-home personal support worker and/or nursing services when needed. • Improved experience in accessing home care services and navigating the health system.
Modernize the provision of long-term care through infrastructure renewal and quality improvement	• Develop and implement local plan to improve facilities of older long-term care homes to ensure all homes meet the same quality standards.	• Older long-term care homes improved through a multi-year plan.
Support caregivers' health and well-being	• Enhance awareness of existing caregiver supports.	• Better support of residents and their caregivers in connecting to the health care services they need.

INFORM - SUPPORT PEOPLE AND PATIENTS – PROVIDING THE EDUCATION, INFORMATION AND TRANSPARENCY ONTARIANS NEED TO MAKE THE RIGHT DECISIONS ABOUT THEIR HEALTH.

IHSP 2016/19	Plan for 2016/17	This will Result In
Increase access to linguistically and culturally appropriate service and care that is welcoming for all	• Assess access to linguistically appropriate services and develop an improvement plan. • Link with provincial collaborations and the Aboriginal community to locally implement provincial directions for First Nations, Metis and Inuit Peoples. • Enhance access to culturally safe services through Indigenous Cultural Safety Training.	• A plan to provide linguistically appropriate services for residents. • Health service providers having the training and tools they need to provide culturally safe services to Aboriginal residents.
Enhance transparent access to information to support professional, patient and caregiver decision-making and transitions of care	• Continue to enhance public access to data on how their health care system is performing. • Engage with primary care and public health to explore need for information related to self-management and illness prevention.	• Residents and health service providers having information about health care system performance through increased information posted online.
Promote access to information to support self-management and illness prevention	• Improve the information about the health system available to residents so they can make informed decisions for self-care.	• Residents having access to information on self-management and illness prevention through online resources.

PROTECT – PROTECT OUR UNIVERSAL PUBLIC HEALTH CARE SYSTEM-MAKING EVIDENCE-BASED DECISIONS ON VALUE AND QUALITY, TO SUSTAIN THE SYSTEM FOR GENERATIONS TO COME.

IHSP 2016/19	Plan for 2016/17	This will Result In
Engage patients, caregivers and community stakeholders in the design and implementation of health care system improvement	• Work with new Patient Ombudsman's Office to implement a best practice framework for a patient complaint and resolution process.	• Residents having clear processes for raising a complaint.
Reduce duplication in testing, assessment and service delivery to create a sustainable system of care	• Reduce unnecessary testing through enhancing best practice knowledge and electronic sharing of results. • Review patient assessments and eliminate duplication.	• More health service providers having access to their patients' information; lab work, diagnostic tests and reports and hospital discharge notes to reduce duplication among providers. • Fewer duplicate assessments.
Integrate services and pursue new models of care to reduce inefficiencies and redirect funding to front-line care	• Work with governors of health service providers to identify opportunities for greater integration in local communities. • Create a value-for-money framework for health system accountability.	• Governors collaborating on common areas of system improvement. • Improved value-for-money in health system investments – more funding to front-line care.

Potential risks/barriers to successful implementation of the Annual Business Plan

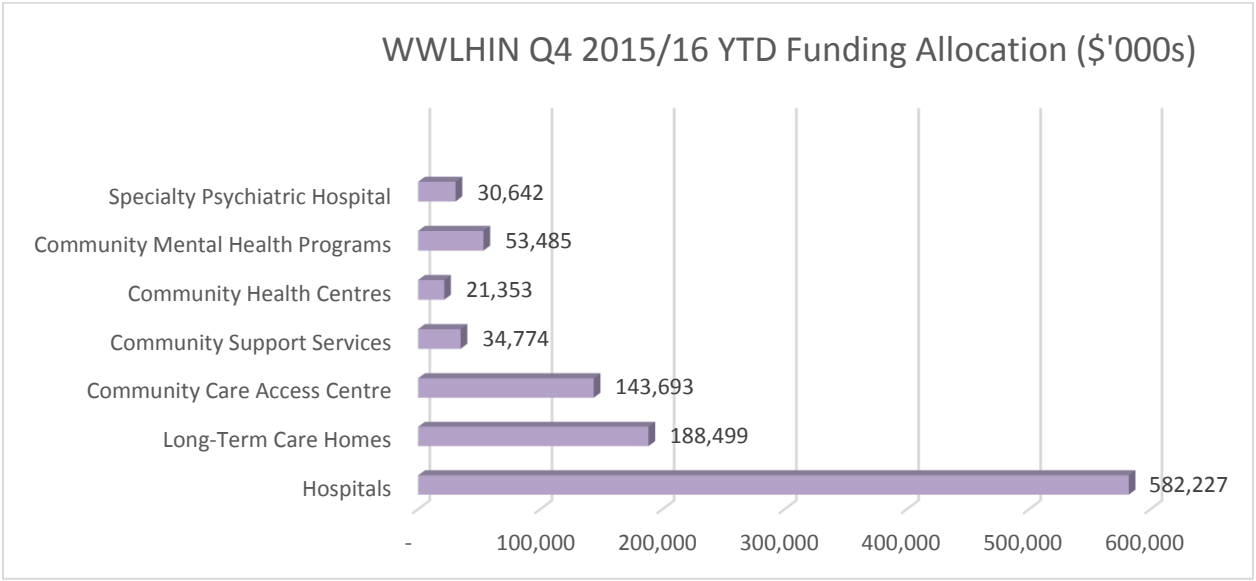
- 2016-17 promises to be a year of opportunity for the health system, not only through the continued focus on local health system improvements identified in the IHSP but also through system improvements across Ontario related to the outcomes of the Patients First Discussion Paper. With multiple improvements occurring simultaneously, the system will be challenged to focus and deliver on the important system improvements while at the same time ensuring continuity of care to ensure no risk to patients.
- Enabling technologies is a foundational element to many of the Annual Business Plan initiatives. We need new solutions to old problems. That means taking on creative and innovative approaches to developing solutions which inherently have an element of risk.
- The adoption of enabling technologies is dependent on buy-in from clinicians. Adoption sometimes requires changes to how clinicians carry out their work and that takes coaching and time.
- Efforts to improve the home and community care experience for our residents will require connecting local efforts to the timing of provincial decisions. There is a risk that delays to the release of guiding provincial decisions may effect progress in implementation at the local level.
- Achieving quality standards requires focus. All health service providers are expected to achieve the quality standards, such as wait times, set out in their service accountability agreements. At the same time, they are also expected to implement other quality improvements identified through specific Quality Based Procedures, the Critical Care Secretariat, the Stroke Network and others. Some providers identify the risk of capacity for change as an issue. Others identify a faster pace and more innovative change as the solution and the slow pace of change as the challenge. The two perspectives need to be managed.
- The Waterloo Wellington LHIN has a robust performance and risk management process, including ongoing risk review and updates to the Board. Any risks identified that would prevent achievement of the initiatives in the ABP are quickly mitigated in collaboration with health service providers and the Ministry of Health and Long-Term Care.

Key enablers to achieve outcomes

- Positive relationships between primary care providers and the Waterloo Wellington LHIN have been established and are continuing to strengthen. Members of the Primary Care Advisory Council offer invaluable direction and insight from the perspective of primary care providers.
- We continue to be fully engaged with the Province in the implementation of the 10 recommendations from the Patients First Home and Community Care Roadmap. Ongoing dialogue ensures planning at the local level is based on the most up-to-date information available.
- Solid partnerships have been developed with health service providers across all sectors of health care through integrated program councils. The Waterloo Wellington LHIN continues to work with partners outside of health care including police services, social service providers and public health. Ongoing collaboration with Health Quality Ontario guides planning at the sub-region level.
- Waterloo Wellington LHIN governors have continued to reach out to health service provider governors through Waterloo Wellington LHIN Board meeting presentations, attendance at Annual General Meetings and governor symposia now held at the sub-region level. There is increasing interest by governors to be engaged in system solutions and to lead in collaborative local health system improvements (e.g. the Rural Way governors and the Guelph Wellington Emergency Mental Health governor collaboration).

Waterloo Wellington LHIN Operations

The Waterloo Wellington LHIN designs, funds and oversees the performance of 74 health service providers, thousands of programs and services and an annual budget of almost $1.1 billion. As of March 31, 2016, the Waterloo Wellington LHIN's funding allocation totaled $1,054,673,430. A summary of our 2015/16 overall allocation is shown in the chart below.



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We work with an internal budget of $6.1 million dollars which represents less than 1% of our total budget. Our internal budget includes funding for the services provided by several physicians including the Waterloo Wellington Physician Leads for Primary Care, Critical Care, Enabling Technologies, Chronic Disease Prevention and Management and Emergency Departments.

Waterloo Wellington LHIN Staffing Plan (Full-Time Equivalents)

We are committed to creating a leading and sustainable health system. Meeting this commitment will require taking on new responsibilities. We have been tasked with providing transformational leadership and collaborating with those who share that vision. To do that, we continue to attract and retain the staff needed to ensure our organization is prepared for this broader role. We will continue to grow our leadership capacity and increase our capabilities as we take on the next set of health system improvements.

Position Title	2015/16 Actuals	2016/17 Budget FTEs	2017/18 Forecast FTEs	2018/19 Forecast FTEs
Administrative Support	6	7	7	7
Professional	6	8	8	8
Management/ Senior Expert	15	16	16	16
Senior Management	2	4	4	4
CEO	1	1	1	1
Total FTEs	**30**	**36**	**36**	**36**

Waterloo Wellington LHIN Operating Budget for Fiscal Year 2016/17

LHIN Operations Sub-Category ($)	2015/16 Actuals	2016/17 Budget	2017/18 Planned Expenses	2018/19 Planned Expenses
Salaries and Wages	4,122,732	4,005,507	4,005,507	4,005,507
Employee Benefits	382,379	394,480	394,480	394,480
HOOPP	352,614	400,870	400,870	400,870
Total Employee Salaries and Benefits	**4,857,725**	**4,800,857**	**4,800,857**	**4,800,857**
Transportation and Communication				
Staff Travel	37,727	40,000	40,000	40,000
Governance Travel	8,351	10,000	10,000	10,000
Communications	37,501	17,000	17,000	17,000
Total Transportation and Communication	**83,579**	**67,000**	**67,000**	**67,000**
Services				
Accommodation	292,292	290,000	290,000	290,000
Community Engagement	26,103	50,000	50,000	50,000
Consulting Fees	129,368	110,000	110,000	110,000
Equipment Rentals	8,146	10,920	10,920	10,920
Governance Per Diems	102,983	115,000	115,000	115,000
LSSO Shared Costs	429,164	452,000	452,000	452,000
Other Governance Costs	54,722	59,000	59,000	59,000
Printing & Translation	48,498	44,000	44,000	44,000
Staff Development	49,514	56,000	56,000	56,000
Total Services	**1,140,790**	**1,186,920**	**1,186,920**	**1,186,920**
Supplies and Equipment				
IT Equipment	65,481	55,000	55,000	55,000
Office Supplies & Purchased Equipment	70,742	71,080	71,080	71,080
Total Supplies and Equipment	**136,223**	**126,080**	**126,080**	**126,080**
LHIN Operations: Total Planned Expense	6,218,317	6,180,857	6,180,857	6,180,857
Annual Funding Target	6,218,317	6,180,857	6,180,857	6,180,857
Variance	-	-	-	-

Looking Ahead

The initiatives laid out in this Annual Business Plan represent the actions that will be taken across the health system over the next year to achieve the objectives identified in the 2016-19 IHSP. Many of these objectives will be accomplished over multiple years. Appendix A provides an estimated timeline for achievement of those objectives.

Finally, as we keep patients, families and caregivers at the center of our work, we are committed to continuing to engage with local residents and stakeholders regularly to better understand their needs and measure our success in improving the health system and the health and well-being of those who live and work in our local communities. Our detailed Communications and Community Engagement Plan (Appendix B) outlines how we will engage with our local communities and how we will communicate back to them the progress that has been made on our commitments.

This is an ambitious plan to improve the health system in our local communities and we are committed to acting on it and putting the needs of our residents first. However, this plan is not our plan – it is the health system's plan, everyone's plan – and it will take each and every one of us working together, in partnership to deliver on this important work.

Appendix A: Action Plans – Initiatives Update

	2016/17		2017/18		2018/19	
	Status	% Complete	Status	% Complete	Status	% Complete
Access						
Engage primary care providers to identify and lead implementation of system improvements in local communities which result in more residents having a primary care provider and better access to after hours and same/next day appointments.	In Progress	30	In Progress	50	Completed	20
Improve coordinated care for residents with complex conditions using Health Links – a care provider they can call who knows them, is familiar with their situation and can help.	In Progress	75	In Progress	15	Completed	10
Create a seamless, coordinated experience for patients discharged from all Waterloo Wellington hospitals to community, including communication with primary care and community based care.	In Progress	60	Completed	40		
Develop sub-region integrated care tables with physician leadership, patient involvement and local leaders that identify and ensure residents get access to care, closer to home.	In Progress	80	Completed	20		
Improve access to specialist care through centralized access.	In Progress	25	In Progress	50	In Progress	15
Improve mental health and addictions services based on needs of patients, including adult intensive services and centralized access.	In Progress	50	In Progress	20	In Progress	20
Expand options for residents needing mental health and/or addiction crisis supports outside of the emergency department.	In Progress	25	In Progress	25	Completed	50
Support residents, providers, and caregivers in planning for end-of-life through access to resources and supports.	In Progress	75	Completed	25		
Improve access to care teams to support patients' comfort measures at end-of-life	In Progress	30	In Progress	30	Completed	40
Enhance community care and pain management options to reduce unnecessary deaths in hospital.	In Progress	30	In Progress	30	Completed	40

	2016/17		2017/18		2018/19	
	Status	% Complete	Status	% Complete	Status	% Complete
CONNECT						
Ensure emergency department, surgical and diagnostic wait times meet the quality standard.	In Progress	50	In Progress	25	In Progress	10
Dramatically improve the patient experience in home and community care through implementing the 10 recommendations from the Patients First Home and Community Care Roadmap.	In Progress	40	In Progress	20	Completed	20
Develop and implement local plan to improve facilities of older long-term care homes to ensure all homes meet the same quality standards.	In Progress	20	In Progress	20	In Progress	20
Enhance awareness of existing caregiver supports.	In Progress	20	In Progress	20	Completed	60

	2016/17		2017/18		2018/19	
	Status	% Complete	Status	% Complete	Status	% Complete
INFORM						
Assess access to linguistically appropriate services and develop an improvement plan.	In Progress	40	In Progress	40	Completed	20
Link with provincial collaborations and the Aboriginal community to locally implement provincial directions for First Nations, Metis and Inuit Peoples.	In Progress	25	In Progress	25	In Progress	25
Enhance access to culturally safe services through Indigenous Cultural Safety Training.	In Progress	annual	In Progress	annual	In Progress	annual
Continue to enhance public access to data on how their health system is performing.	In Progress	40	In Progress	40	Completed	20
Engage with primary care and public health to explore need for information related to self-management and illness prevention.	In Progress	10	In Progress	40	In Progress	40
Improve the information about the health system available to residents so they can make informed decisions for self-care.	In Progress	10	In Progress	30	In Progress	30

	2016/17		2017/18		2018/19	
	Status	% Complete	Status	% Complete	Status	% Complete
PROTECT						
Work with new Patient Ombudsman's Office to implement a best practice framework for a patient complaint and resolution process.	In Progress	20	In Progress	30	Completed	50
Reduce unnecessary testing through enhancing best practice knowledge and electronic sharing of results.	In Progress	25	In Progress	25	In Progress	25
Review patient assessments and eliminate duplication.	In Progress	40	Completed	60		
Work with governors of Health Service Providers to identify opportunities for greater integration in local communities.	In Progress	40	In Progress	40	In Progress	20
Create a value-for-money framework for health system accountability.	In Progress	40	Completed	60		

Appendix B: Communications & Community Engagement Plan

Communication Objectives

In support of the three focus areas of increasing timely access to primary care, improving the home care experience and continuing to focus on quality, we will leverage existing communications tools and look for new opportunities to strengthen stakeholder relationships, provide accurate information about health system priorities and build partnerships.

Target Audiences

The creation of a truly patient- centered health system cannot occur without clear communication and frequent engagement with key stakeholders. Our efforts in 2016-17 will be intentionally focused on patients, families and caregivers. We will also put special focus on engagement with primary care providers as we work to better understand how we can help them help their patients and with health system governors as we work to develop system level partnerships at a Sub-region level. This work will be aligned with the Ministry of Health's *Patients First: Ontario's Action Plan for Health Care* and will support the provincial engagement initiatives for P*atients First: A Proposal to Strengthen Patient Centered Health Care.*

Residents/Patients/Families/Caregivers

Our residents are at the center of everything that we do. As we work to drive forward initiatives that improve the patient experience and support caregivers, we will actively engage our residents through a variety of communications methods with the aim of better understanding what health services are important to them and where they see gaps in the system.
We will also work with our health service providers, community leaders and other key stakeholders to ensure residents will have the information they need to make informed choices about their care and decisions about available health resources.

We will use the following methods to communicate and engage with our residents.

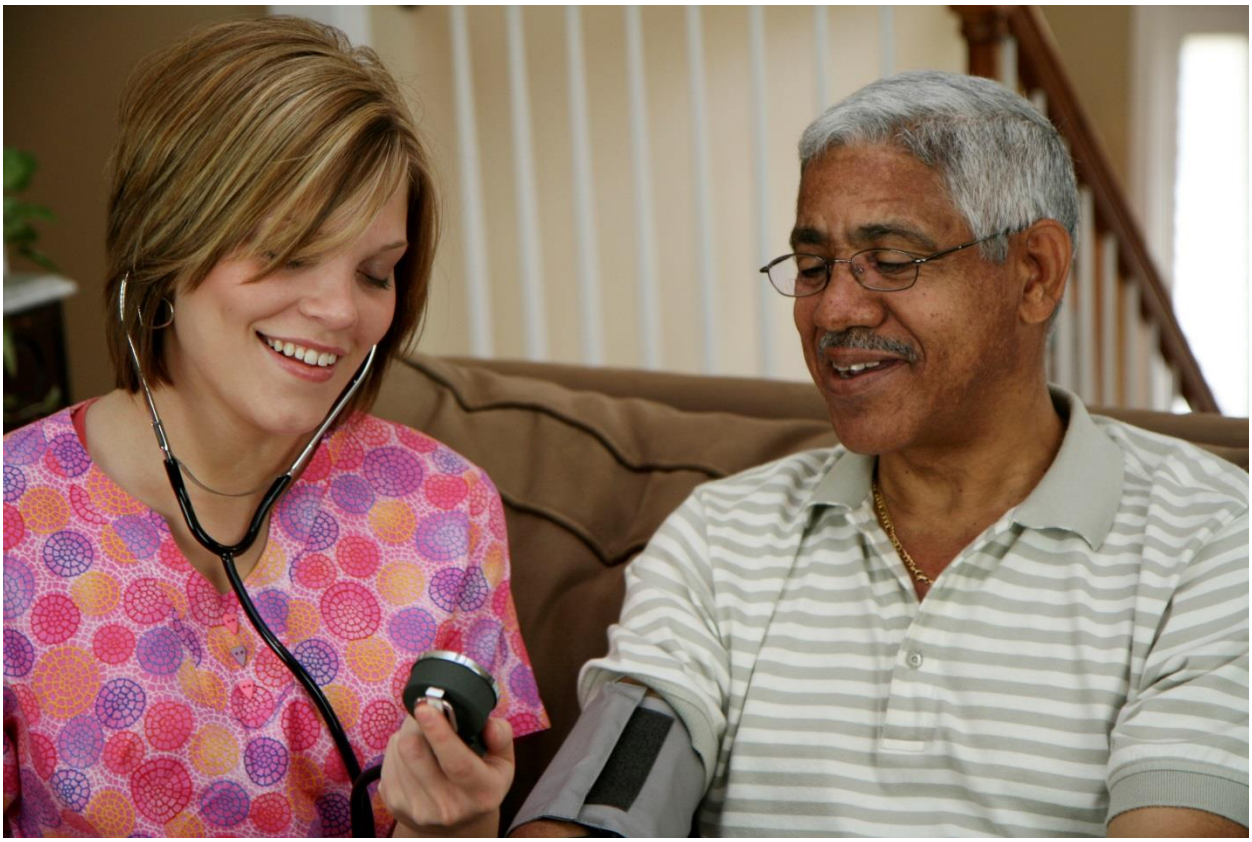
- Surveys
- Focus groups
- Community events
- Website – refresh to make more resident friendly
- Social media
- Blog
- Traditional media – news releases/stories
- Newsletter
- Resolving and tracking resident concerns

Primary Care Providers
As the hub of our health system, we will engage with primary care to better understand what they need to increase access to same and next day appointments and to connect them with additional health services to better support their patients.

- Engagement Events
- Newsletter
- Website – specific pages for primary care
- Social media
- Blog
- Network and Council meetings
- Facilitating connections between physicians and other providers

Health System Governors
We will engage health system governors to make decisions that consider the needs of our population and the broader health system. We will work with them to build partnerships and support the integration of care services that are needed to provide residents with a seamless care experience and contribute to building a responsive, sustainable health care system.

- Governor engagement sessions
- Newsletter
- Website – Governance resources
- Governors profiles
- Targeted updates from our Board meetings
- Social media
- Blog



In addition to these, below is a list of stakeholders and partners with whom we will engage through a variety of methods to build partnerships, share information and feedback and assess our success to support our strategic objectives. We will further refine our engagement plan on continual basis to ensure the right stakeholders are engaged and to maximize the plan's impact.

- Local Health System Provider Leadership
- Front-line Staff
- Local Health Professionals Advisory Council
- Primary Care Advisory Committee
- Various Networks/Councils (Addictions and Mental Health, Community Support Services, Geriatric Services, Emergency Services, etc.)
- Internal Staff
- Waterloo Wellington LHIN Board of Directors
- Elected Officials
- Media
- Municipalities
- Public Health
- School Board
- Private Sector
- Ministry of Health and Long-Term Care
- Police/Community Safety
- Social Services Sector
- Post-secondary education
- Others

Engaging our diverse residents

Diversity is part of what makes Waterloo Wellington unique. As we move forward with our plan for system improvement, we will be especially focused on the overall health of our population and inequities in our system.

Specific effort will also be taken to engage with specific target groups including our Aboriginal and Francophone communities. We work with the Entity[2] to identify the specific health care needs and priorities of francophone residents. We will also place special focus on engaging with marginalized and frequently underserved populations who experience statistically poorer health outcomes to identify ways to address their unique health needs.

Measuring our success

The true success of our communication and community engagement initiatives is measured by our ability to understand the needs of our local stakeholders and translate that understanding into actionable items. We are committed to measuring our success against the expectations of our local residents, identified through engagement activities and through common communications metrics. By measuring our performance, we can continuously find ways to improve our work and achieve the best health outcomes of residents. The following is a list of the performance measure indicators we utilize to do this:

- Consistent use of the Community Engagement Tracker with increased number of engagements each quarter.
- Increased social media following and level of social media engagement, including blog traffic and social media impressions.
- Increased traffic to website.
- Exposure of LHIN successes in traditional media (print, radio).
- Consistent use of the LHIN visual identity and key messages.
- Participant evaluation integrated into every community engagement plan and used to inform future engagement planning.