Central West **LHIN**
**RLISS** du Centre-Ouest


# Annual Business Plan 2013 - 2014

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

# Table of Contents

March 28, 2013

Ms. Catherine Brown
Assistant Deputy Minister,
Health System Accountability and Performance Division
Ministry of Health and Long-Term Care
Hepburn Block, 5th Floor
80 Grosvenor Street
Toronto, Ontario M7A 1R3

Dear Ms. Brown:

**Re: 2013-14 Annual Business Plan**

In accordance with the requirements of the Local Health System Integration Act 2006 and the obligations under the Agency Establishment and Accountability Directive, please find enclosed the Central West LHIN's 2013-14 Annual Business Plan. The Annual Business Plan is one of the two components of the Annual Service Plan process and details the LHIN's multi-year planning for the local health system. The Annual Business Plan describes how the Central West LHIN is progressing with the directions of our third Integrated Health Services Plan (IHSP 3).

This Annual Business Plan 2013-14 has been approved by the Central West LHIN's Board of Directors.

Sincerely,

Maria Britto
Board Chair of the Central West LHIN

Scott McLeod
Chief Executive Officer of the Central West LHIN

# A Message from the Board Chair and CEO

The Central West LHIN is pleased to present the 2013-2014 Annual Business Plan (ABP). Every year the Central West LHIN develops a formal business plan that outlines how the LHIN will implement the strategic directions and initiatives articulated in the Integrated Health Services Plan.

The third Integrated Health Services Plan (IHSP 3) was developed after extensive consultation with local residents, Health Service Providers and community leaders. Four strategic directions will improve the quality and access to health care services in the Central West LHIN between April 2013 and March 2016.

To better implement the LHIN's strategic directions, the Annual Business Plan is separated into sections according to the initiatives of the IHSP. Each section highlights the current status of each initiative, actions to be completed and their impacts.

As a forward-looking document, the 2013-2014 Annual Business Plan is building on the successes of previous years' work across the Central West LHIN. While many of the directions are based on provincial priorities, this document also reflects more local priorities, aimed at better meeting the needs of our growing population.

The Central West LHIN's work is focused on the development of an integrated system of health services aimed at improving access to the right services in the right place at the right time. As we implement this Annual Business Plan we will move closer to achieving our objective.

Maria Britto
Board Chair of the Central West LHIN

Scott McLeod
Chief Executive Officer of the Central West LHIN

# Board of Directors

**Maria Britto**
*Chair*
June 9, 2011 –
June 8, 2014

**Lorraine Gandolfo**
*Member*
Oct. 27, 2010 –
Oct. 26, 2013

**Suzan Hall**
*Member*
May 17, 2011 –
May 16, 2014

**Winston Isaac**
*Member, reappointed*
Jan. 13, 2012 –
Jan. 12, 2015

**Hon. John McDermid**
*Member*
June 9, 2011 –
June 8, 2014

**Gerry Merkley**
*Member*
June 17, 2010 –
June 16, 2013

**Pardeep Singh Nagra**
*Member*
June 9, 2011 –
June 8, 2014

**Ken Topping**
*Member*
Oct. 6, 2010 –
Oct. 5, 2013

# Introduction

The Central West LHIN's third Integrated Health Services Plan 2013-2016 (IHSP 3) describes the LHIN's strategic directions aimed at improving local health care. It covers the period April 1, 2013 to March 31, 2016. The IHSP 3 aligns with Ontario's Action Plan for Health Care, in which the province sets actions to build a health system that is more responsive to residents requiring health care services, and delivers improving quality of care and value for money. The IHSP 3 also reflects alignment with Pan-LHIN Imperatives, which focuses LHIN's collective efforts across Ontario.

The Annual Business Plan, which is a key component of the Ministry/LHIN Performance Agreement (MLPA), outlines how the LHIN will implement the strategic directions and initiatives set out in the IHSP 3, and how it will measure the LHIN's performance in the year.

The strategic directions and initiatives detailed in the IHSP 3 will be outlined in the Annual Business Plan. The Current Status section provides context to each initiative by giving information about the current environment. The highlighted Key Action Items are indicative of the breadth and depth of the LHIN's work. The following section presents Expected Impacts of these Key Action Items, which are focused on the MLPA performance measures and measures outlined in the IHSP3. The last section outlines Risks and Key Enablers. Additionally, various Mitigation Strategies are provided to demonstrate the type of activities to take place locally to address Risks. These are not all inclusive Risks, Key Enablers and Mitigation Strategies but demonstrate the types that will likely impact most greatly on the completion of the specific initiatives. Ultimately, the success of this plan will be documented in the Annual Report, which looks back on the work done in the previous year, reporting on the LHIN's achievements.

As an extension of the IHSP 3, the Annual Business Plan indicates how, in partnership with Health Service Providers and the community, the Central West LHIN will work to improve the health of residents who live within the LHIN's geographic boundaries.

## Mandate and Strategic Directions

Under the Local Health System Integration Act (LHSIA), the Central West LHIN has the legislated authority to plan, coordinate, integrate, fund and monitor the local health care system for the purpose of improving the health of residents who live in communities within the LHIN's geographic boundaries. Based on this mandate, the Central West LHIN established its strategic directions using 5 guiding principles:

1. Equitable access based on patient/client need.
2. Preservation of patients'/clients' choice.
3. People-centred, community-focused care that responds to local population health needs.
4. Measurable, results-driven outcomes based on strategic policy formulation, business planning and information management.
5. Shared accountability between providers, government, community and citizens.

The IHSP 3 is aligned with the Provincial Government's *Action Plan for Health Care,* launched by the Ministry of Health and Long-Term Care in January 2012. In turn, Health Service Providers are expected to align their strategic plans with the Integrated Health Services Plan.

The Annual Business Plan ensures time and resources are focused strategically because health systems are complex and have many competing requirements. Both the IHSP 3 and the Annual Business Plan ensure that the LHIN directs its energy toward the initiatives that will best serve the residents in the Central West LHIN.

Over the next three years, the Central West LHIN will focus its time and attention on four strategic directions: ***Improve Access to Care, Streamline Transitions and Navigation of the System, Drive Quality and Value, and Build on the Momentum***. Initiatives that will be undertaken by the LHIN are identified for each strategic direction.

### I. Improve Access to Care

i. Improve access to Primary Health/Family Health Care.
ii. Improve access to chronic disease prevention & management programs, with an emphasis on diabetes.
iii. Improve access to mental health and substance abuse services, with a focus on youth.
iv. Improve access to community-based services for seniors.

### II. Streamline Transitions and Navigation of the System

i. Improve linkages with and among Primary / Family Health Care and other providers in the health care system.
ii. Improve system navigation resources.
iii. Increase system collaboration through use of information technologies.

### III. Drive Quality and Value

i. Ensure an overarching LHIN quality framework.
ii. Optimize use of health care resources to foster better value.

### IV. Build on the Momentum

i. Aboriginal Health
ii. Diversity and Health Equity
iii. French Language Services
iv. Palliative Care
v. Women and Children's Health

These strategic directions and initiatives support the Central West LHIN's vision, which is to create a local health system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren.

## Overview of current and forthcoming programs/activities

### Central West LHIN by the Numbers

The Central West LHIN provides access to quality health care to over 876,000 residents, with an annual budget of $810 million. Home to 6.2% of the Ontario population, the Central West LHIN is growing at a much faster pace than the rest of the province and almost half of its population are newcomers.

| Health Service Providers | Funding (2011-12) | % of Total Budget |
|---|---|---|
| Community Care Access Centre | $89,894,132 | 11% |
| Community Health Centres and their satellite locations | $9,971,451 | 1.2% |
| Mental Health & Addiction Services | $30,170,891 | 3.7% |
| Community Support Services Organizations | $14,564,148 | 1.8% |
| Long-Term Care Homes | $148,528,033 | 18.3% |
| Hospital Corporations | $516,802,550 | 63.8% |
| Total | $809,931,205 | 100% |

# Performance of Central West LHIN

The Ministry-LHIN Performance Agreement (MLPA) is the annual contract between the Ministry of Health and Long Term Care and the LHIN that sets performance targets for 15 health system indicators, 14 of which apply to the Central West LHIN. The table below shows quarterly Central West LHIN performance against these targets, with the most recent data available as of 11 February 2013.

**CENTRAL WEST LHIN PERFORMANCE INDICATORS**

**February 11, 2013 Release**

| | PI No. | Performance Indicator (PI) | 2011/12 | | | 2012/13 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | LHIN Starting Point or Baseline | LHIN Target | 14-May-12 | LHIN Starting Point or Baseline | LHIN Target | 13-Aug-12 | 13-Nov-12 | 11-Feb-13 |
| MLPA INDICATORS | | ALTERNATE LEVEL OF CARE AND EMERGENCY ROOM (ER) | | | | | | | | |
| | 1 | Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution [2] | 9.55% | 9.46% | 10.44% | 9.69% | 10.00% | 11.67% | 9.60% | 10.34% |
| | 2 | 90th Percentile ER Length of Stay for Admitted Patients* [1] | 30.63 | 26.50 | 43.10 | 37.20 | 30.60 | 31.63 | 32.48 | 38.30 |
| | 3 | 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients** [1] | 8.72 | 8.40 | 7.53 | 7.85 | 7.00 | 7.00 | 7.23 | 7.33 |
| | 4 | 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients [1] | 4.23 | 4.00 | 3.85 | 3.78 | 4.00 | 3.70 | 3.67 | 3.52 |
| | | SURGICAL AND DIAGNOSTIC WAIT TIMES | | | | | | | | |
| | 5 | 90th Percentile Wait Times for Cancer Surgery [1] | 61 | 57 | 58 | 54 | 57 | 57 | 55 | 55 |
| | 6 | 90th Percentile Wait Times for Cardiac By-Pass Procedures [1] | NA | NA | NA | NA | NA | NA | NA | NA |
| | 7 | 90th Percentile Wait Times for Cataract Surgery [1] | 99 | 90 | 225 | 164 | 180 | 211 | 144 | 132 |
| | 8 | 90th Percentile Wait Times for Hip Replacement [1] | 171 | 171 | 209 | 189 | 190 | 230 | 230 | 216 |
| | 9 | 90th Percentile Wait Times for Knee Replacement [1] | 185 | 175 | 240 | 208 | 210 | 256 | 232 | 238 |
| | 10 | 90th Percentile Wait Times for Diagnostic MRI Scan [1] | 130 | 82 | 80 | 80 | 80 | 80 | 82 | 51 |
| | 11 | 90th Percentile Wait Times for Diagnostic CT Scan [1] | 21 | 25 | 26 | 25 | 25 | 28 | 15 | 14 |
| | | EXCELLENT CARE FOR ALL/QUALITY | | | | | | | | |
| | 12 | Readmission within 30 Days for Selected CMGs [3] | 15.19% | 14.70% | 16.49% | 15.33% | 14.70% | 13.19% | 13.15% | 16.19% |
| | | MENTAL HEALTH AND SUBSTANCE ABUSE | | | | | | | | |
| | 13 | Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions [3] | 15.30% | 14.84% | 16.19% | 14.84% | 14.10% | 14.30% | 15.87% | 15.87% |
| | 14 | Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions [3] | 18.40% | 17.90% | 21.15% | 20.10% | 18.50% | 24.13% | 21.31% | 26.42% |
| | | ACCESS TO COMMUNITY CARE | | | | | | | | |
| | 15 | 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management) [2] | 19.00 | 19.00 | 22.00 | 20.00 | 19.00 | 20.00 | 29.00 | 40.00 |

# Key Accomplishments

Over the past several years, the LHIN has worked diligently, in collaboration with Health Service Providers, to realize the vision of a local health system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren. The following recent achievements highlight the success of this work.

## Access to Care

The Central West LHIN has worked diligently to improve access to care. Examples include:

- Behavioural Supports Ontario – BSO, an initiative aimed at enhancing services for elderly persons with complex behaviours due to dementia, mental health or other neurological conditions.
- Clients of community mental health and addiction services have greater access to psychiatrists and family doctors through psychiatric sessionals for case consultation and staff education. In the last three years, over 30 full-time positions have been added to frontline care for mental health and addictions and mental health and addiction services investments increased by almost $11.5M since 2007.

- Assess and Restore additions to Headwaters Health Care Centre and William Osler Health System have created new capacity for seniors who require additional time to recover before going home or beginning rehabilitation services.
- William Osler Health System has redesigned its stroke program at their Brampton Memorial Hospital site to group stroke patients and implement best practices.
- The Geriatric Outreach Program supports seniors in multiple care locations.
- The Nurse Practitioner Outreach Program assists Long-Term Care homes in managing ill residents who may otherwise be sent to the Emergency Department.
- Transportation services by Caledon Community Services, CANES Community Care and Dufferin County Community Support Services that support seniors to attend day programs, be seen by Physicians and participate in activities that support their capacity to remain in their homes.
- Programs to provide home making and home maintenance to support seniors in their homes.

## Integration

The Central West LHIN has focused its work on improving integration. Specific achievements include:

- Fostering communities of practice through the Central West LHIN Palliative Care Network, Concurrent Disorder Network, Mental Health and Addictions Systems Integration Project and Regional Renal Coordinating Centre and the Centre for Complex Diabetes Care.
- Continuing the dialogue, collaborative planning and collective action with providers through Core Action Groups – Diversity and Health Equity, French Language Services, Mental Health and Addiction Services, Services for Seniors, and Women and Children's Health.
- Supporting the adoption of the Physician Electronic Medical Record and Connecting GTA as two examples of work to reduce duplication and improve integration of information.
- Community mental health and community support service providers have fully implemented the Community Care Information Management Common Assessment and Integrated Assessment Record initiatives which support Health Service Providers to develop and securely share client information (with consent).
- Supporting the use of Advance Practice Nurses to coordinate Palliative Care among providers.
- A memorandum of understanding between Headwaters Health Care Centre and William Osler Health System to support Orthopedic Care and streamline the total joint replacement process for people from Dufferin.
- Supporting the expanded role of Central West Community Care Access Centre to centralize access to care through assessment and placement to adult day programs and assisted living programs.

## Diversity and Health Equity

In recognition of the diversity of the communities in the Central West LHIN and individuals' experiences with the local health care system, the Central West LHIN and local Health Service Providers have focused on Diversity and Health Equity. Achievements include:

- The Central West LHIN established the Diversity and Health Equity Core Action Group, comprised of representatives from local Health Service Provider organizations, which has worked to identify specific local strategies to promote culturally-competent health care services and ensure equitable access to care.
- In partnership with the Diversity and Health Equity Core Action Group, the LHIN developed and conducted a Health Equity Environmental Scan. This assisted Health Service Providers to identify the status of their work in health equity and set the foundation from which organizations can develop individual health equity plans. Information was also used to inform the key priorities for the Core Action Group to focus on moving forward.
- The LHIN, in partnership with the Ministry of Health and Long-Term Care, is implementing the Health Equity Impact Assessment Tool (HEIA), a flexible and practical assessment tool that can be used to identify potential health impacts (positive or negative) of a plan, policy or program on vulnerable or disadvantaged groups within the general population. LHIN staff and the Diversity and Equity Core Action Group have been trained on the tool.

# Key Drivers of System Change

### Aboriginal Health

Aboriginal engagement is guided by the Local Health System Integration Act (2006), advising the LHINs to focus on meeting the needs and priorities of the Aboriginal peoples and communities in the area and to respond to health care service delivery issues affecting the Aboriginal peoples.

### Clinical Utilization

Because Ontario residents can choose where to get health care services, regardless of which LHIN they live in, it is important to track where people are receiving their care in order to make planning decisions. More patients are leaving Central West LHIN to receive hospital care than are coming into the LHIN for their care. This is consistent with the activity in other GTA LHINs, where much of the patient flow is into the Toronto Central LHIN for specialized care and treatment at academic teaching hospitals. The objective is to increase local access to a broader range of health services for residents in the Central West LHIN. The Central West LHIN has good data about those who use hospital services. While data is improving, the LHIN is not certain about the extent to which residents in the Central West LHIN use community-based services outside the LHIN, other than services provided by the Central West Community Care Access Centre. Anecdotally, the Central West LHIN is aware that persons do leave the LHIN boundaries to seek community-based care, especially community-based mental health and addictions services.

### Chronic Disease / Diabetes

The Central West LHIN is working to ensure a more integrated health system for residents living with diabetes in the communities in the Central West LHIN. 11.4 % of the population has diabetes, which constitutes the 3rd highest rate in Ontario. 36% of the Central West LHIN's population has one chronic condition, while 14% have multiple chronic conditions. An ideal integrated system would support patients to manage their chronic diseases and move more easily through the health care system in which providers have ready access to important health information.

### Community Services Funding Increase

The Central West LHIN allocated the base funding increases to the community sector for fiscal year 2012-13 of $5.5 million to support investments in home care and community services to better serve seniors and other Ontarians who would benefit from care provided in the community.

### Diversity of Population

The Central West LHIN has one of the most diverse populations in Ontario. Over half of the people living in the LHIN are visible minorities as compared to the province where one fifth of the population are visible minorities. 45.6% of Central West LHIN's population are newcomers, as compared to 28.3% in Ontario. There are challenges that must be addressed in communicating with all of the residents in the Central West LHIN – and opportunities to deepen the LHIN's relationships with local ethno-cultural communities.

### French Language Services Act (FLSA)

The FLSA guarantees to all persons and corporate entities the right to communicate with the government and its agencies, boards and commissions, in French, and to receive services in French. As a Crown Agency, the Central West LHIN is committed to increasing access and accessibility to French language health services by meeting the requirements of the FLSA and those of the Local Health System Integration Act.

### High Users of Health Care Services

The Central West LHIN undertook an analysis of their "high users" of hospital and homecare services. High users are patients who, because of their health condition, use a high amount of hospital and homecare resources, which translates into

greater health care expenses. Understanding the needs of these patients provides information that the LHIN and Health Service Providers require to improve planning for the delivery of health services and to build capacity to meet the needs of these individuals. Information about “high users” includes: Brampton has one of the largest numbers of “high users” in Ontario; North Etobicoke has the highest rate of high users in the LHIN, followed by Dufferin County, and Brampton; Seniors comprised about half of the high users population; the top 1% of high users accounted for 33% of ALC days; 83% of high users used a combination of care types in the hospital and homecare settings. The LHIN is working on the implementation of Health Links, a new model of care with an initial focus on high users, where all Health Service Providers in a community, including primary care, hospitals and community care, are charged with coordinating integrated care plans at the patient level.

### Local Health System Integration Act (LHSIA)

LHSIA gives the Central West LHIN the power to plan, coordinate and fund health care providers located within its geographic boundaries. The LHIN will engage the community and Health Service Providers to identify needs, reduce inefficiencies and improve access to high quality, patient-centred health services.

### Mental Health & Addictions

The Central West LHIN’s rate of growth in visits to a health care provider for Mental Health and Addictions is 21.7% compared to an Ontario average of 13.9%. The number of Emergency Department visits for Mental Health and Substance Abuse is increasing and the community support wait times for mental health and substance abuse are longer than the Ontario average.

The guiding goals of Ontario’s Mental Health and Addictions Strategy (June 2011) are to improve the health and well-being for all Ontarians, to create healthy, resilient, inclusive communities, to identify mental illnesses and addictions problems early and intervene, and to provide timely, high quality, integrated, person-directed health and other human services. The Ministry of Health and Long-Term Care, in partnership with three other ministries, has begun to implement the first three years of the strategy known as Ontario’s Three-Year Child and Youth Mental Health Strategy by funding and providing support to expand child and youth mental health services.

### Population Growth Rate

The Central West LHIN has a higher than average growth rate. The LHIN is home to 6.2% of the population of Ontario and continues to grow. Between 2006 and 2011, the population in the Central West LHIN grew 11.2%, faster than Ontario’s growth rate of 5.6%. The fastest growing age group is those over 75 years of age – at 36.3% growth rate, significantly higher than the Ontario average. This rapidly growing population means that even though the rate of Emergency Department visits is steady, the volume has increased. Between 2008 and 2012, the increase in Emergency Department volumes in the Central West LHIN was double the provincial increase. The birth rate is also very high in Central West LHIN and this LHIN holds the highest life expectancy in the province.

### Primary Health Care

Family health care is the hub of the health care system for most people. Family physicians (or a primary health care team) are ideally the first point of contact with the health care system when someone needs medical attention, unless it is an emergency. Outside of the hospital, the family physicians also provide follow-up care and refer patients to more specialized professionals. Ontario’s Action Plan for Health Care identifies faster access to primary care, more ways to gain access to family health care resources, and the introduction of quality measures to family health care, as key components of a fully integrated system. The goal is to ensure appropriate care from family care providers, to deliver right care in the right place at the right time, and to help reduce hospital admissions. Health Links, the new integrated model of care currently being implemented in Ontario, will ensure an efficient linkage between Primary Care and the rest of the health care system.

### Seniors Care

In January 1013, Dr. Samir Sinha, the Provincial Seniors Strategy Expert Lead, released *Living Longer, Living Well*, a comprehensive report on how to help seniors stay healthy and live at home longer. The recommendations cover health and wellness, social services, and community living for older Ontarians and will inform Ontario’s Seniors Strategy.

# Improve access to Primary Health/Family Health Care

## IHSP Initiative Description

The LHIN will work with Family Health Teams, Community Health Centres and other primary care practitioners to ensure that patients have timely access to multi-disciplinary primary care, that care is provided in appropriate settings as close to home as possible, and to reduce avoidable visits to the emergency department. This work can be expected to reflect province-wide developments in improving models of care and the integration of primary care.

### Strategies

- Work with Family Health Teams and other primary care practitioners to ensure that clients have timely access to multi-disciplinary primary care as close to home as possible.
- Provide care in appropriate primary care settings to reduce inappropriate hospital use.

## Current Status

- The Central West LHIN has a complement of seven Family Health Teams.
- Central West LHIN residents are also served by the Bramalea Community Health Centre (CHC) and the Rexdale CHC. Rexdale CHC also operates the Jamestown and Kipling Dixon Satellites, while Bramalea CHC operates Four Corners Health Centre in Malton. Together the CHCs serve a variety of Central West LHIN priority populations that experience barriers to health services, such as members of linguistic or cultural groups, individuals with low incomes, individuals who are homeless, isolated seniors, individuals with mental health and addiction issues, and the sexual/gender diverse.
- The LHIN has established a Primary Care Council. This group, to be led by the physician Primary Care Lead, will further develop partnerships and engagement strategies with local physician groups.
- As one of three LHINs selected for the provincial Telehomecare pilot project, the Central West LHIN is implementing this strategy to remotely link providers and patients. As applied to residents with chronic obstructive pulmonary disease and congestive heart failure, Telehomecare aims to improve patient self-management, decrease hospitalization and the use of emergency department and walk-in clinics, while improving self-reported quality of life and health outcomes.
- Together with McMaster University and local Family Health Teams, the Central West LHIN has recently completed an evaluation of Interprofessional Care. The research and related results will assist primary care providers in their understanding of and approach to expanding interprofessional care.

## Consistency with Government Priorities

Ontario's Action Plan for Health Care released in January of 2102 outlines the goal of having a family health care provider for every Ontarian who wants one and to provide more patients with faster and more convenient access to this care. The Ministry of Health and Long-Term Care continues to improve access to family health care and reduce the number of Ontarians who do not have a family physician. A total of 250 Family Health Teams are operational or at various stages of development across the province, which will provide access to primary care for more than three million Ontarians.

In late December 2012, the Ministry of Health and Long-Term Care announced the creation of Health Links. Health Links will encourage greater collaboration between existing local health care providers, including family care providers, specialists, hospitals, long-term care, home care and other community supports. With improved coordination and information sharing, identified "high user" patients will receive faster care, will spend less time waiting for services and will be supported by a team of health care providers at all levels of the health care system.

| Action Items / Interventions | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Establish Health Links in five geographic areas. | In progress 80% | 20% | |
| Focus on “high user” populations with complex needs, who access care from multiple providers or are disadvantaged/marginalized – struggle to get the care they needs, when and where they need it. | In progress 25% | 25% | 25% |
| Work with Health Links and Health Care Connect to ensure that clients who do not have a primary care practitioner are assigned one upon discharge. | Not yet started 25% | 25% | 25% |
| Work with Family Health Teams and other primary care practitioners to ensure that clients have timely access to multi-disciplinary primary care and specialty care as close to home as possible. | Not yet started 25% | 25% | 25% |

**As per the MOHLTC guide, the status of the work (Not yet started, In progress, Deferred, or Completed), and if applicable, the percentage completion anticipated in each of the next three years is indicated.*

## Expected Impacts of Key Action Items (How We Will Measure Success)

- Increase percentage of registered patients referred to a family physician through Health Care Connects within 30 days of request to 30% from current percentage of 26.4%.
- Set baseline and reduce the rate of emergency visits that can be managed elsewhere (conjunctivitis, cystitis, otitis media, upper respiratory infection).

## Risks/Barriers to Successful Implementation

- Year-over-year population growth will increase pressures on the availability of access to local family physicians for residents in the LHIN. Mitigation:
  - o continue to use Health Care Connect to document referrals to primary care to determine and understand access status.
  - o monitor progress of Health Links implementation.
- Access to and communication of relevant patient information. Mitigation:
  - o the eHealth infrastructure that will improve client-based information availability and management is in the process of being built.

## Key Enablers that Will Allow the LHIN to Achieve its Goals

- Build on the strong partnerships with local Family Health Teams and Community Health Centres and their commitment to develop relationships with acute care and community partners.

# Improve access to chronic disease prevention and management programs, with an emphasis on diabetes

## IHSP Initiative Description

The LHIN will work with community partners to increase capacity for self-management of chronic conditions to improve treatment and management of chronic diseases in the community. This work will include the improved coordination of regional diabetes services to expand access to diabetes education and self-management programs for local residents. The intention is to provide various means to support individuals to actively self-manage their chronic diseases, complications and comorbidities in partnership with their providers, expanding from the work in diabetes.

## Current Status

- Diabetes prevalence has increased to 11.4% in 2011 from 10.9% in 2010 and exceeds the average provincial prevalence of 9.7%. The Central West LHIN has the third highest diabetes prevalence in the province.
- According to the Canadian Diabetes Association, evidence suggests the increased prevalence may be attributed to a predisposition to diabetes in the ethno-culturally diverse populations in the LHIN.
- The Central West LHIN is incorporating work previously undertaken by the Central West Diabetes Regional Coordination Centre into its operations, expanding to incorporate work across other chronic diseases.
- The Central West LHIN currently has a total of 11.5 Ministry of Health and Long Term Care (MOHLTC) funded diabetes education programs that are delivered by five Health Service Providers across the LHIN. There is capacity to serve more patients in these programs.
- Chronic Disease Self-Management Programs include a peer led program for individuals at risk for or living with chronic conditions as well as a program for health care providers supporting patient care.
- The rate of retinal eye examinations for people living with diabetes in the Central West LHIN has improved from 2009 and is 62.2% in 2011, though lower than the provincial average of 67.6%.
- One of the key ways the LHIN will support self-management of chronic diseases is through implementing a regional Telehomecare Program, currently directed to patients with Chronic Obstructive Pulmonary Disease (COPD) and Chronic Heart Failure (CHF) and targeting patients who have had a recent ED and/or hospital admissions. William Osler Health System (Osler) is currently the host organization of the program and is actively involving the Community Care Access Centres (CCAC), Family Health Teams and Community Health Centres, and other health care providers, to bring Telehomecare to appropriately identified patients across the Central West LHIN.

### Strategies

- Work with community partners to increase capacity for self-management of chronic conditions to improve treatment and management of chronic diseases in the community.
- Expand education and self-management programs for chronic diseases based on work undertaken with diabetes.

## Consistency with Government Priorities

The Ontario Chronic Disease Prevention and Management Framework is an approach to Chronic Disease Prevention and Management that is client centered, evidence-based and population focused. The Central West LHIN is strongly committed to improving access to Chronic Disease Prevention and Management Programs by building on the foundations of the Ontario Chronic Disease Prevention and Management Framework and the work of local the diabetes programs and expanding to other chronic diseases to promote, prevent and delay the onset of chronic disease.

The Central West LHIN Telehomecare Program aligns with provincial goals to support patients living with complex chronic conditions. The program is one of three pilot programs across the province that aim to transform the provincial chronic disease prevention and management (CDPM) model of care by bringing together existing programs and fostering a continuum of care. The program also focuses on fostering collaboration among health care providers by driving integrated care plans and care coordination.

| Action Items / Interventions | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Transition of the Diabetes Regional Coordination Centre to the Central West LHIN. | In progress 100% | | |
| Transition of the Diabetes Education Programs to the Central West LHIN. | Not yet started 100% | | |
| Diabetes Education Programs will implement and report on performance improvement plans and progress towards meeting annual program targets (expected to be reviewed and set with the MOHLTC). | In progress 20% | 20% | 20% |
| Continue to meet or exceed targets for the Chronic Disease Self-Management Programs for individuals at risk for or living with chronic diseases and health service providers delivering care. | In progress 25% | 25% | 50% |
| Build on the Chronic Disease Prevention and Management model implemented for diabetes in the Central West LHIN and apply principles across other chronic diseases that impact on the health of local residents. | Not yet started 25% | 25% | 50% |
| Implement Telehomecare pilot in partnership to support patients with chronic obstructive pulmonary disease and congestive heart failure, meeting targets. | In progress 50% | 50% | |
| Apply a health equity lens to evaluate for barriers to accessing care at Diabetes Education Programs using the Health Equity Impact Assessment tool. | In progress 60% | 40% | |
| Develop and pilot 3 integrated care pathways for the management of diabetes in the Central West LHIN. | In progress 66% | 33% | |

## Expected Impacts of Key Action Items (How We Will Measure Success)

- Reduced number of emergency room visits for both hyperglycemia and hypoglycemia by 10% by 2014. As of the second quarter in 2011-12, Emergency Department visits for hyperglycemia and hypoglycemia were 74 visits at Headwaters Health Care Centre, 188 visits at Etobicoke General Hospital and 421 visits for Brampton Civic Hospital.

## Risks/Barriers to Successful Implementation

- Consistent processes for referral to Diabetes Education Programs in the region need to be implemented across the sub LHIN areas. Mitigation:
  - o transition of Diabetes Education Teams into LHIN purview will improve monitoring and accountabilities.
- Variation in engagement and active participation of primary and specialty care providers. Mitigation:
  - o focused engagement by LHIN now with expanded responsibilities for engagement, planning and integration of for diabetes.
- Realistic targets for Telehomecare need to be confirmed. Mitigation:
  - o targets being set by host organization, Ministry of Health and Long-Term Care and LHIN based on identification of those individuals who can benefit from program.

## Key Enablers that Will Allow the LHIN to Achieve its Goals

- Based on previous work, continue to develop partnerships with Diabetes Networks, Professional Practice groups, Primary Care Providers and Family Health Teams throughout the region.
- Use of Health Links focused on high users and those with chronic conditions can be expected to improve coordination and knowledge across health system providers.
- The integration of IT with implementation of the Integrated Care Pathways will improve care transitions, enable timely communications, facilitate collaboration and improve efficiency.
- Telehomecare implementation will require a collaborative integrated plan and leadership team.

## Improve access to mental health & addictions services, with a focus on youth

### IHSP Initiative Description

The LHIN will work with community partners to increase capacity for community-based programs and to improve early intervention for youth and young adults. This work will align with Ontario's Comprehensive Mental Health and Addictions Strategy and its early focus on children and youth.

### Current Status

- In the last three years in the Central West LHIN, over 30 full-time positions have been added to frontline care, while investments increased by almost $11.5M since 2007.
- The ministries of Health and Long-Term Care and Children and Youth Services share a provincial strategy for youth mental health and are both undergoing system transformation.
- Community mental health providers have fully implemented Common Assessment and Integrated Assessment Record initiatives which support Health Service Providers to develop and securely share client information (with consent).
- Communities of practice are fostered through the Concurrent Disorders Network and the multi-sector Systems Integration Project.
- The number of emergency department visits for Mental Health and Substance Abuse is increasing; Central West LHIN residents make up roughly 4% of active cases, admissions and discharges in Ontario's psychiatric units; Mood Disorders (40%) & Schizophrenia (38.5%) account for the largest patient populations.
- Rate of growth in visits to a health care provider for Mental Health and Addictions is 21.7%, compared to an Ontario average of 13.9%.
- Average wait times for mental health case management, counselling and treatment, early intervention, diversion and court support, and support within housing were greater than province.
- Residential treatment, community treatment, and initial assessment and treatment planning for addictions have very long average wait times for services offered in the LHIN.

#### Strategies

- Work with community partners to increase capacity for community-based programs.
- Work with community partners to improve early intervention for youth-at-risk.

### Consistency with Government Priorities

The initiative and outcomes reflect alignment with Ontario's Action Plan for Health Care and there are clear links to "Open Minds, Healthy Minds", Ontario's Comprehensive Mental Health and Addictions Strategy.

| Action Items / Interventions | 2013/14 | 2014/15 | 2015/2016 |
|---|---|---|---|
| Execute the work plan to address repeat visits within 30 days for mental health and substance use. | In progress 50% | 25% | |

| Action Items / Interventions | 2013/14 | 2014/15 | 2015/2016 |
|---|---|---|---|
| Ensure alignment of the Peel Service Collaborative to cross-sector planning in the Central West LHIN. | In progress 50% | 30% | |
| Support the Community Care Access Centre to integrate the school mental health nurses program in cross-sector service delivery. | In progress 100% | | |
| Ensure alignment of the eating disorders program expansion to sector and system planning in the Central West LHIN. | In progress 100% | | |
| Monitor and support local implementation of the Narcotics Strategy, including utilization of Ontario Telemedicine units. | In progress 50% | 25% | 25% |
| Adopt and execute a coordinated access model for mental health and addiction services. | Not yet started 50% | 25% | 25% |
| Develop a LHIN-wide strategy and provider plans to improve age-appropriateness of services for youth and capacity to intervene earlier. | Not yet started 50% | 50% | |

## Expected Impacts of Key Action Items (How We Will Measure Success)

- Positive impact on the Ministry-LHIN Performance Accountability indicator to reduce the number of repeat, unplanned emergency visits within 30 days for mental health, particularly those patients with three or more repeat visits, to MLPA target.
- Positive impact on the Ministry-LHIN Performance Accountability indicator to reduce the number of repeat, unplanned emergency visits within 30 days for substance abuse, particularly those patients with three or more repeat visits, to MLPA target.
- Set baseline and reduce rate of ED visits in youth (aged 16-24) for mental health and substance abuse conditions.
- Set baseline and increase proportion of eligible residents in the Central West LHIN to mental health case management by Connex Ontario within 30 days of request.

## Risks/Barriers to Successful Implementation

- Existing structures and expertise of adult health service providers and youth-serving agencies may not adequately facilitate the change management required. Mitigation:
  - LHIN to help facilitate and monitor progress of discussions with providers about opportunities to share expertise and align structures and priorities that better support system transformation.
- Providers' capacity to respond on a timely basis and the clinical stages of change experienced by people with substance use issues may preclude reduction of repeat visits. Mitigation:
  - understand and accept nature of addictions and help-seeking behavior, discussions with providers about service models that are more responsive to residents at the time help is sought.
- Program implications and costs of coordinated access model while yet to be determined may be too significant to justify proceeding with execution of the preferred model: Mitigation:
  - LHIN to learn early in the process from other LHINs the costs/considerations incurred in their implementation, ensure that the choice of models put forward is scalable.

## Key Enablers that Will Allow the LHIN to Achieve its Goals

- Capacity and sustained commitment of hospital and community mental health and addiction health service providers and child and youth serving agencies to collaborate and change.
- Continued alignment of complex system transformations across ministries.
- Cross-LHIN collaboration.
- Inter-operability of electronic information systems.

# Improve Access to Care

## Improve access to community-based services for seniors

### IHSP Initiative Description

Seniors comprise 11% of the population of the Central West LHIN and this percentage is increasing. Over the past decade the Ministry of Health and Long-Term Care and the Central West LHIN have introduced a number of strategies and programs to improve the support for seniors to live independently in their own homes. The Central West LHIN will continue to focus on activities to improve access to community-based services as the preferred alternative to institutional care in hospitals and long-term care homes.

### Current Status

- In 2011/12, seniors comprised 11% of the population of the Central West LHIN and this percentage is expected to grow to 12% by 2016 and 13.7% by 2021. The fastest growing age group in the Central West LHIN is 65 to 74 years of age with a projected increase of 66.4% by 2016.
- Seniors account for 50% of the high users of health care in the Central West LHIN.
- There were 17,614 hospital admissions of seniors from the Central West LHIN in 2011/12. Seniors accounted for 9.5% of all Alternate Level of Care (ALC) cases and 16.4% of ALC days.
- Senior residents of the Central West LHIN made 40,663 emergency department visits in 2011/12, 77% of those were to hospitals within the Central West LHIN. Seniors accounted for 16% of all emergency department visits made by residents of the Central West LHIN.
- Over the past five years, the Central West LHIN has made strategic investments in services for seniors including Regional Geriatric Program, Geriatric Emergency Management (GEM), Behavioural Supports Ontario (BSO) program in Long-Term Care, Home Care, Nurse Led Outreach Teams, Palliative Care, Assisted Living and Supportive Housing, Assess and Restore beds, Psychogeriatrics, Adult Day Programs and Transportation.
- The Central West LHIN participates in the provincial roll out of innovations in community-based assessment and placement such as the expanded role of the CCAC in adult day programs (completed), and assisted living and supportive housing (in progress).
- Both Headwaters Health Care Centre and the William Osler Health System are participants in the Seniors Friendly Hospital Strategy.
- The Provincial Framework for Falls Prevention has been introduced to Health Service Providers in the Central West LHIN.
- The Behavioural Supports Ontario initiative, including the mobile crisis service, has been successfully implemented in all 23 Long-Term Care homes. BSO Support is also available to hospitals, adult day programs and primary care environments.

#### Strategy

- Work with LHIN-funded community services to develop strategies to support seniors in the community; this work will align with the province's Seniors Care Strategy.

### Consistency with Government Priorities

The Central West LHIN Seniors Strategy will incorporate elements of:

- The Ministers Action Plan for Health Care that encouraged LHINs to develop a seniors strategy with an intense focus on supporting seniors to stay healthy and stay at home longer.
- The report *Living Longer, Living Well,* written by the Provincial Seniors Strategy Expert Lead Dr. Samir Sinha, addresses the health, social and community care needs of older Ontarians. The report identifies five principles for a Seniors Strategy: Access, Equity, Choice, Value and Quality.

| Action Items / Interventions | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Develop a comprehensive seniors strategy for the Central West LHIN based on the recommendations in *Living Longer, Living Well.* | Not yet started 100% | | |
| Work with hospitals, primary care providers and Health Link partners to ensure all seniors are connected to a primary care provider. | Not yet started 80% | 20% | |
| Promote early discharge planning practices using system level, consistent admission criteria, facilitated by automated systems such as Resource Matching and Referral. | In progress 20% | 50% | 30% |
| Streamline the assessment and referral processes for assisted living and supportive housing and adult day programs. | In progress 100% | | |
| Increase the availability of sub-acute and geriatric rehabilitative care programs and support the development of assess and restore options. | In progress 20% | 30% | 50% |
| Meet performance targets in short stay programs and assisted living and supportive housing environments. | In Progress 50% | 50% | |
| Fully integrate the new and existing community nursing models (e.g. GEM, Nurse Led Outreach Teams, Rapid Response Nurses, Palliative Care Nurses and Telehomecare nurses) to support "warm hand offs". | In Progress 50% | 25% | 25% |
| Continuously improve the falls prevention programs in Health Service Providers. | In Progress 50% | 50% | |
| Sustain the gains and improvements to the Behavioural Supports Ontario (BSO) program. | In Progress 34% | 33% | 33% |

## Expected Impacts of Key Action Items (How We Will Measure Success)

- Increase the number of seniors cared for in the community and reduce the 90$^{th}$ percentile wait time for CCAC in-home services by one day.
- Set baseline and decrease the number of ALC days for seniors.

## Risks/Barriers to Successful Implementation

- The high rate of growth in the seniors population in the Central West LHIN will put increasing pressure on access to health services. Mitigation:
  - o continue to monitor growth and impact, development of local seniors strategy, opportunities through funding support, use of new initiatives – Telehomecare, Health Links.
- To be successful, there is a need for culturally-appropriate approaches to the delivery of all services for seniors. Mitigation:
  - o use of Health Impact Assessment Tool, development of Health Equity Plans, support for Health Service providers with expertise in serving diverse communities.
- Availability of certain health care professionals (e.g. nurse practitioners) may impact on the ability to staff programs (e.g. Nurse Led Outreach, Palliative Care). Mitigation:
  - o support local Health Service Providers, where able, in recruitment efforts and continue to inform Ministry of Health and Long-Term Care of local challenges with provincial initiatives.

## Key Enablers that Will Allow the LHIN to Achieve its Goals

- The LHIN will continue to support programs and services originally funded under the Aging at Home initiative that are meeting their accountability targets.
- Networks of key stakeholders will proactively review performance results and strategize ways to improve the complete spectrum of services for seniors.
- Ongoing, active participation of primary care providers.

## Improve linkages with and between Primary Health/ Family Health Care & other providers in the health care system

### IHSP Initiative Description

The LHIN will increase coordination of CCAC care within primary care settings to ensure the provision of the right community-based care. The LHIN will work with providers to ensure that clients who do not have a primary care practitioner are assigned one upon discharge. The LHIN will focus on populations with complex needs, who access care from multiple providers or are disadvantaged – marginalized and struggle to get the care they needs, when and where they need it.

### Current Status

- The Central West LHIN supports the establishment of five Health Links in the LHIN: Bolton – Caledon, Bramalea and Area, Brampton and Area, Dufferin Area and the North Etobicoke-Malton-West Woodbridge.
- The Central West Community Care Access Centre is developing strategies to increase alignment with primary care. The strategies will improve the care for all clients with a focus on collaborative care planning in primary care settings for complex clients who utilize intensive resources.
- Together with the Community Health Centres, the LHIN is adopting Health Equity Impact Analysis. This is particularly relevant to the CHCs given the priority populations they serve that experience barriers to health services such as individuals with varying cultural and language needs, individuals with low incomes, individuals who are homeless, isolated seniors, individuals with mental health and addiction issues, and the sexual/gender diverse.
- The LHIN has established a Primary Care Council, led by the physician Primary Care Lead, to further develop partnerships and engagement strategies with local physician groups.
- As one of three LHINs selected for the provincial Telehomecare pilot project, this project will link patients with complex chronic conditions to remote support. Prospective patients will be identified by primary care providers with the aim to improve patient self-management, decrease hospitalization and the use of emergency department and walk-in clinics, while improving self-reported quality of life and health outcomes. Telehomecare will be an important component in the establishment of Health Links and the identification of high users, who would benefit by improved linkages.

#### Strategies

- Increase coordination of CCAC care in primary care settings to ensure the provision of the right community-based care.
- Work with providers to ensure that clients who do not have a primary care practitioner are assigned one upon discharge.
- Focus on populations with complex needs, access care from multiple providers or are disadvantaged/ marginalized and struggle to get the care they need, when and where they need it.

### Consistency with Government Priorities

Ontario's Action Plan for Health Care released in January of 2102 outlines the goal of having a family health care provider for every Ontarian who wants one and to provide more patients with faster and more convenient access to this care. Contributing to this is the Ministry of Health and Long-Term Care announcement of the development of Health Links. Health Links will encourage greater collaboration between existing local health care providers, including family care providers, specialists, hospitals, long-term care, home care and other community supports. With improved coordination and information sharing, identified "high user" patients that will receive faster care, will spend less time waiting for services and will be supported by a team of health care providers at all levels of the health care system.

| Action Items / Interventions | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Establish Health Links in five geographic areas. | In progress 80% | 20% | |
| Health Links to ensure that high user clients are identified and each high user has a care plan which encompasses Health Link partners across health care providers. | Not yet started 25% | 25% | 25% |
| CCAC care established in primary care settings to ensure the provision of the right community-based care. | In progress 50% | 50% | |

## Expected Impacts of Key Action Items (How We Will Measure Success)

- Reduction in the number of ALC days in acute inpatient hospital beds, linked to improvement in meeting MLPA target.
- Reduction in the avoidable use of ER for Non-Admitted Minor Uncomplicated (CTAS IV-V), linked to improvement in meeting MLPA target.
- Reduce the readmission rate within 30 days for selected Case Mixed Groups (CMG), linked to meeting MLPA target.

## Risks/Barriers to Successful Implementation

- Year-over-year population growth increasing pressures on the availability of access to local family physicians for residents of the LHIN.
  - o continue to use Health Care Connect to document referrals to primary care to determine and understand access status.
  - o monitor progress of Health Links implementation.
- Access to and communication of relevant patient information. Mitigation:
  - o the eHealth infrastructure that will improve client-based information availability and management is in the process of being built.

## Key Enablers that Will Allow the LHIN to Achieve its Goals

- Strong partnerships and commitment for system change with Primary Care Providers and community based service providers.
- Relationships with local Family Health Teams and Community Health Centres and their commitment to develop relationships with acute care and community partners.

# Streamline Transitions & Navigation of the System

## Improve system navigation resources

### IHSP Initiative Description

The LHIN will work with community-based and hospital-based providers to understand and address access barriers. The LHIN will work with providers to develop integrated care pathways and care plans to help people understand where and when to access the health care they need after being discharged from a hospital. The LHIN will partner with community and government agencies to strengthen system navigation and support the establishment and use of services, such as Healthline, which provide information about health care services and how to gain access to them.

### Current Status

### Access Barriers

- A fast growing, rapidly aging and highly ethno-culturally diverse population faces some challenges in gaining access to appropriate and timely health care services.
- Access to eight Adult Day Programs is now managed by the Central West CCAC. Referrals are received centrally with a single wait list.
- The Behavioural Supports Ontario (BSO) initiative is available to Long-Term Care homes, hospitals, adult day programs and primary care environments.
- There are five organizations offering Assisted Living and Supportive Housing programs in the Central West LHIN. The Central West CCAC is in the process of centralizing the referral and waiting list for these services.
- There is limited hospital-based outpatient rehabilitation available in the Central West LHIN.
- The Central West LHIN funds three organizations to provide transportation for seniors.

#### Strategies

- Work with community-based and hospital based providers to understand and address access barriers.
- Work with providers to develop integrated care pathways and care plans to assist people with navigating the system post-hospital discharge.
- Partner with community and government agencies to strengthen system navigation.
- Support the establishment and use of services such as Healthline which provide one-point information about health care services and how to gain access to them.

### Post-Discharge Care Pathways

- In alignment with the Patient Flow Process Improvement strategy to be accomplished as part of the "optimize use of health care resources to foster better value for money" initiative, the Central West LHIN will work with health service providers to develop post-discharge care plans for all patients discharged from Central West LHIN hospitals.

### Transitions in Care

- The health care system can improve in the provision of support to patients being discharged from the hospital to support their re-adjustment to life in the community. Great strides have been made in the Central West LHIN in improving hand-offs between in-hospital care and the care available in the community (primary care, CCAC, community-based services, and family/friends) with the establishment of Home First. Health Links will improve care for seniors and others with complex conditions.

### Facilitating Navigation

- One strategy underway to make navigation easier for residents and for providers in the Central West LHIN is Healthline, a one-point service providing information about health care services and how to access them managed by the Central West CCAC. Healthline, in conjunction with other similar tools, provides the opportunity to partner with community and government to strengthen ease of navigation for consumers and for providers.

## Consistency with Government Priorities

### Access Barriers

- Ontario's Action Plan for Health Care focuses on ensuring patients are receiving care in the most appropriate setting, wherever possible at home instead of in hospital or Long-Term Care. Inherent in this objective is the addressing and removal of barriers to access.

### Care Pathways

- *Caring for Our Aging Population and Addressing Alternate Level of Care* ("the Walker report") recommended that "Hospitals adopt best practice rehabilitation care pathways, primarily for patients who are recovering from hip and knee joint replacement, hip fractures or stroke."

### Transitions in Care

- The Action Plan for Health Care refers to local integration of health care, with a particular focus on family health care. These priorities are reflected in the CCAC expanded role, the ongoing support of Home First, and the establishment of Health Links.

### Facilitating Navigation for the Consumer

Ontario's Action Plan for Health states: "*There are still too many instances where patients don't know how to access the care they need, don't know what services are available or are waiting in hospital until home care or long-term care are available. Better integration through our local health networks will put the right care in the right place for the benefit of patients and the system. We can do better. We need a patient-centred system that has better integrated health providers - such as family health care, community care, hospitals and long-term care - that moves patients more seamlessly from one care setting to another*."

| Action Items / Interventions | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Develop and implement post-acute/post-discharge plan<br>• Adult Day Programs<br>• Assisted Living and Supportive Housing<br>• Respite services. | Not yet started<br>25% | 25% | 50% |
| Develop integrated best practice rehabilitation care pathways and care plans for patients discharged from hospitals – identify initial pathway improvement opportunities. | Not yet started<br>50% | 50% | |
| Implement recommendations of the Transportation Study to improvement productivity and meet activity targets. | In progress<br>75% | 25% | |
| Support promotion of Healthline. | On-going | On-going | On-going |

## Expected Impacts of Key Action Items (How We Will Measure Success)

- All prospective clients for assisted living, supportive housing, and adult day programs will be assessed and placed by the CCAC through establishment of a centralized wait list.
- Reduce wait times for CCAC in-home services from community setting to MLPA target.

## Risks/Barriers to Successful Implementation

- Local capacity/flexibility to improve effectiveness and productivity. Mitigation:
  - o strong senior management sponsorship, application of change management processes, senior management focus on accountabilities and timelines, celebration of small successes to encourage further movement.
- Need to sustain change and possibility to revert to old ways of doing things. Mitigation:
  - o establish routine check-ins and reports on ongoing processes, in addition to the removal of old tools and the establishment of barriers to reversion to old methods will reduce this risk.

- Issues may be identified that require pan-LHIN discussion and/or provincial input, and cross-ministerial issues may be identified that can't be resolved locally. Mitigation:
  - LHIN will work with Health Service Providers, other LHIN's, and the Ministry of Health and Long Term Care to address these risks.
- Availability of reliable data. Mitigation:
  - The LHIN Decision Support Unit will work with its counterparts at the local and provincial level to establish and use the most appropriate data sets.

## Key Enablers that Will Allow the LHIN to Achieve its Goals

- Collaboration of other funders.
- Access to readily accessible information.
- Clear identification of each process, with clear timelines, objectives, and accountabilities.
- Strong senior management buy-in and support at all involved HSP's and at LHIN.
- Allocation of sufficient time and resources for staff engagement, training, and internalization.
- Commitment of all staff to supporting change and sustainability.

# Streamline Transitions & Navigation of the System

## Increase system collaboration through use of information technologies

### IHSP Initiative Description

Information integration is essential to improving the patient experience, connecting providers and supporting patient or client self-management.

A major provincial priority in Ontario is achieving a greater exchange of electronic information across Ontario's health system. eHealth Ontario (eHO) has set an ambitious strategy to implement an Electronic Health Record (EHR) by 2015. In addition, eHealth Ontario, the Ontario Association of Community Care Access Centres (OACCAC), the Ministry of Health and Long Term Care (MOHLTC), and Cancer Care Ontario (CCO) are driving provincial initiatives that will impact a major set of HSPs in each LHIN. Achieving the vision for an EHR requires intense participation and coordination in a variety of electronic health system initiatives at the provincial, regional, and local levels.

The LHIN will participate in provincial, regional and local initiatives to develop and establish information management and communications tools to share and access system and client information across services. Health Links is one program that will look to leverage the tools that have been developed and are currently being developed. Additionally, the LHIN will continue to facilitate the establishment of physician electronic medical records (EMRs) and other health record initiatives and, they will work with hospitals and primary care practitioners to ensure timely discharge information is accessible by the primary care practitioners.

### Current Status

- Headwaters Health Care Centre is currently live on Hospital Report Manager (HRM) as a pilot hospital with plans to expand to additional physicians in 2013/14. William Osler will go live with HRM as part of the ConnectingGTA in 2013/14.
- Increasing the adoption of Physician Electronic Medical Record systems within the LHIN continues to be a focus. The percentage of specialists in the LHIN who have an Electronic Medical Record (EMR) is 49% while the percentage of other physicians is 76%.
- The Community Care Information Management (CCIM) common assessment tools and the Integrated Assessment Record (IAR) have been successfully implemented with many of our Mental Health and Community Support Service providers. Continued implementations are planned for the Central West CCAC, Long Term Care.
- Currently, the Ontario Lab Information System (OLIS) has collected approximately 60 per cent of the provincial total test volumes through connections with eleven hospitals, four community labs and public health labs. William Osler Health system is scheduled to feed OLIS its test volumes in March 2013 and discussions with Headwaters Health Care Centre have commenced. In addition to the hospitals contributing data, clinicians can now view data through their Specification 4.x EMRs. Implementation has been completed with 65 Central West clinicians and is underway with many others

#### Strategies

- Participate in provincial, regional and local initiatives to develop and establish information management and communications tools to share and access system and client information across services.
- Continue establishment of electronic medical record initiatives and other health record initiatives, such as the integrated assessment records.
- Work with hospitals and primary care practitioners to ensure timely discharge summaries and related information is accessible by the primary care practitioners.

- The ConnectingGTA project continues to work with the health care providers to provide a single point of access to patient health information. William Osler Health system is a Wave 1 hospital for this initiative, with a targeted go-live date of November 2013 for populating and/or accessing data regionally.
- Representatives from the Central West LHIN, acute care facilities, CCAC and long term care are working on the Alternate Level of Care Resource Matching & Referral Business Transformation Initiative (RM&R BTI) to develop provincial standard referral forms and work flow processes for the four core RM&R pathways. The standardized referral forms and processes are targeted to be piloted in 2013/14 with provincial rollout planned for 2014/15.
- In addition to the provincial ALC RM&R BTI work, the Central West LHIN and five other GTA LHINs are working together to procure an automated solution that will support the provincial resource matching and referral work.
- The hospital Rapid Electronic Access to Clinical Health (REACH) product that allows data exchange between hospital systems has been upgraded to a new platform. Work continues on the next phases of a joint Common Hospital Information System (HIS) for the Central West and Mississauga Halton LHINS.
- The Central Ontario LHINs Project Management Office (PMO) continues to mature. One area of focus is the increase in adoption of an enterprise Project Portfolio Management (PPM) tool (Eclipse) to facilitate improved project planning and tracking.

## Consistency with Government Priorities

A major provincial priority in Ontario is to achieve a greater exchange of electronic information across Ontario's health system. The Ministry of Health and Long-Term Care in partnership with eHealth Ontario have set an ambitious strategy to implement an Electronic Health Record (EHR) by 2015. Participation in Health Links, ConnectingGTA, OLIS, Resource Matching & Referral, Hospital Report Manager and other initiatives mentioned above offer significant partnering opportunities for Health Service Providers. In addition, innovative electronic health system solutions must continue to be found to support integration of information in and across community agencies e.g. the Integrated Assessment record.

A greater exchange of electronic information enables Ontario's Action Plan for Health Care by better integrating a patient's information and more seamlessly enabling the patient transition from one care setting to another.

| Action Items / Interventions | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Expand the implementation of Hospital Report Manager. | In Progress 50% | 25% | |
| Continue to increase the adoption of Physician EMRs. | In Progress 14% | 10% | |
| Continue to implement the IAR in the LTC and Addictions sectors. | In Progress 15% | 15% | |
| Implement hospital lab data feed to OLIS and clinician view. | In Progress 60% | 30% | |
| Implement the Connecting GTA – Provider Portal and Health Information Access Layer (HIAL). | In Progress 50% | 25% | |
| Implement Resource Matching & Referral Business Transformation Initiative. | In Progress 15% | 20% | 30% |
| Complete Procurement of a Central Ontario LHINs RM&R Automated Solution. | In Progress 50% | | |
| Continue work required to implement a Common Hospital Information System. | In Progress 20% | 20% | 20% |
| Conduct a Central West LHIN HSP IM/IT Environmental Scan. | Not yet started 100% | | |

## Expected Impacts of Key Action Items (How We Will Measure Success)

- Improved electronic sharing of and access to patient information across Health Service Providers. (Number of users actively searching the IAR, number of electronic referrals across HSPs, number of hospitals and physicians who have implemented HRM, number of reports transmitted electronically from hospitals to physician EMRs, number of Central West LHINs whose EMRs are connected to OLIS, number of lab results access by Central West LHIN clinicians through OLIS, reduction in number of ALC days for hospital patients waiting to transition to Rehab/CCC, CCAC in-home services or Long-Term Care).
- Continued increase in EMR implementation and adoption. (Percentage of family practice physicians and specialists who have implemented an EMR).

## Risks/Barriers to Successful Implementation

- Limited resource capacity among participating HSPs. Mitigation strategy:
  - o obtain an understanding of HSP priorities s and align project plans and activities where possible.
  - o identify a champion/credible health lead for the project
  - o build stakeholder awareness, engagement and buy in as early as possible.
- Uncertainty regarding long-term funding and potential new government priorities may impact engagement and participation of health care system stakeholders and champions. Mitigation strategy:
  - o reinforce through stakeholder communications information re: healthcare funding.
  - o ensure timely delivery of LHIN priority information and provincial priority information.
- Competing initiatives (internal or external) take precedence over the project in question. Mitigation strategy:
  - o ensure frequent communications to the project lead if it is not a LHIN led initiative.
- HSP funding for the project does not cover all costs the HSPs incurs to implement. Mitigation strategy:
  - o ensure that all costs to be borne by the HSPs for the project are known and communicated up front.
  - o identify and communicate quantifiable benefits of the project up front.
  - o if there are known unrecoverable project costs for HSPs, ensure it is communicated in advance of obtaining HSP commitment.
- Ongoing costs of the implemented solution must be incurred by the HSPs. Mitigation strategy:
  - o ensure that a sustainability model is created and communicated to the HSPs and LHIN in advance of committing to project implementation.

## Key Enablers that Will Allow the LHIN to Achieve its Goals

- Clear accountabilities/responsibilities among stakeholders
- Effective change management practices/tools are in place to support effective adoption.
- Adoption of the solution by stakeholders.
- Ability to use any asset developed on a larger scale.
- Have a positive effect on an IHSP indicator(s)
- The timely release of funds for eHealth and Ministry of Health and Long-Term Care projects/initiatives is important.
- Ongoing partnerships with other LHINS, delivery partners and Health Service Providers will enhance the ability to leverage already developed regional solutions.
- The timely release of funds for eHealth and Ministry of Health and Long-Term Care projects/initiatives is important.
- Ongoing partnerships with other LHINS, delivery partners and Health Service Providers will enhance the ability to leverage already developed regional solutions.
- Must ensure that a sustainability model is created and communicated to the HSPs and LHIN in advance of committing to project implementation.

# Drive Quality and Value

## Ensure an overarching LHIN quality framework

### IHSP Initiative Description

The Central West LHIN is committed to providing leadership for quality in support of the Excellent Care for All Act and the Ontario Action Plan for Health. The LHIN has the opportunity to drive improvement in treatment, care and safety through the development of an overarching framework for quality that articulates system level aims and how all Health Service Providers across the Central West LHIN can contribute to the achievement of these aims.

The LHIN will leverage its focus on quality to support the objectives of IHSP 3 initiatives. The LHIN will work in partnership with the Ministry of Health and Long-Term Care, Health Quality Ontario and local Health Service Providers to advance strategies designed to build capability and capacity for improvement and safety. This will help embed and sustain a culture of continuous quality improvement across the Central West LHIN that will be enhanced by the incorporation of patient/client experience into quality indicators and requiring the completion of accreditation processes and quality improvement plans by all Health Service Providers as part of accountability agreements.

### Current Status

- The Board of Directors of the Central West LHIN has identified quality as an important focus in its governance role. In order to provide leadership for quality, a Quality Committee of the Board will be developed and begin work in 2013-14. Once in place, the Quality Committee will provide an important oversight role in guiding the implementation of the Central West LHIN Quality Framework.
- The Central West LHIN's role in performance monitoring through MLPA Performance Reporting and Health Service Provider quarterly reports provides an overview of the status of the local health care system relative to important indicators of quality. The Central West LHIN and its stakeholders continue to identify important areas to improve processes and outcomes of care.
- A number of provincial strategies are underway to build capability and capacity for quality improvement. This includes IDEAS which is being coordinated by the MOHLTC's Health Quality Branch, focused initially on supporting the roll out of Health System Funding Reform and quality based procedures. Through Health Quality Ontario (HQO) a new initiative called BestPATH will provide tools, expertise and resources to local Health Links to address gaps in the quality of care and service delivery for individuals with complex chronic illnesses. Both initiatives will be optimized to ensure local Health Services Providers benefit from the learning and resources available to support local improvement efforts.
- The introduction of the Excellent Care for All Act (ECFAA) requires all hospitals to complete Quality Improvement Plans (QIPs) for submission to Health Quality Ontario for review and to provide these plans, for information, to the LHINs. Hospitals will submit their third round of QIPs in 2013/14 and primary care organizations (Community Health Centres, Family Health Teams and Nurse Practitioner Led Clinics) will submit their first QIPs in 2012/13. It is anticipated that community Health Service Providers and Long-Term Care homes will also be required to complete and submit QIPs over the next several years to support full implementation of ECFAA.

#### Strategies

- Support the establishment of education and training programs aimed at improving treatment, care and safety based on leading practices.
- Build capacity for improvement and safety.
- Incorporate patient/client experience in quality indicators.
- Develop a collaborative and integrated approach with Health Services Providers to support the development of quality improvement plans.
- Support community-based Health Services Providers to undertake accreditation processes.

- Health services accreditation is an important process for all LHIN-funded organizations to undertake to help identify areas of excellence and where gaps exist relative to quality standards of care. A number of Health Service Providers have successfully completed the accreditation process through different recognized accreditation organizations.

## Consistency with Government Priorities

The development of an overarching quality framework for the Central West LHIN is consistent with government priorities related to the Excellent Care for All Act (ECFAA) and the Ontario Action Plan for Health. In particular, this initiative and the associated strategies support the principles of ECFAA which include: quality and its continuous improvement is a critical goal across the health care system; care is organized around the person to support their health; quality of care is supported by the best evidence and standards of care; and payment, policy and planning support quality and efficient use of resources. The Ontario Action Plan for Health builds on ECFAA by setting clear directions for patient's to receive the right care at the right time in the right place.

| Action Items / Interventions | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Establish Quality Committee of Central West LHIN Board. | Not yet started 100% | | |
| Develop and implement a Central West LHIN Quality Framework including identification of system level aims for improvement, alignment of existing and new LHIN cross-sector initiatives/projects and integration of quality improvement methodologies. | In progress 100% | | |
| Establish and coordinate a Central West LHIN Quality Improvement (QI) Capability and Capacity Building Initiative that incorporates provincial and regional processes, tools and resources from IDEAS, BestPATH and other evidence-informed approaches and promotes learning and exchange through an annual Central West QI Learning Forum. | In progress 50% | In progress 50% | |
| Support completion of quality improvement plans as part of Health Service Provider's accountability agreements. | In progress 100% | | |
| Support completion of accreditation process for all community-based Health Service Providers including documentation of accreditation status and planning for completion for any non-accredited organizations as part of Health Service Provider's accountability agreements. | Not yet started* | | *Note: non-accredited HSPs will be given to March 31, 2017 to complete accreditation |

## Expected Impacts of Key Action Items (How We Will Measure Success)

- Establish baseline Falls indicators across hospital and Long-Term Care homes and set targets for improvement as part of Quality Improvement Plans.
- Percentage of nosocomial infection indicators decrease in keeping with hospital Quality Improvement Plans.
- 100% of accredited HSPs will have provided documentation of accreditation status, including plan for on-going accreditation to the LHIN, by March 31, 2014.
- 100% of non-accredited HSPs will have provided a plan for accreditation by March 31, 2014 including proposed accreditation organization and time line for completion.

## Risks/Barriers to Successful Implementation

- Competing demands, duplication or inconsistency related to initiatives designed to support quality improvement at a provincial and regional level. Mitigation:
  - o establish LHIN-wide Quality Framework, based on best-practice.
- Variation in the capacity of HSPs to commit the required time and resources at governance, clinical and administrative leadership and front-line levels to drive improvement in quality. Mitigation:
  - o LHIN will work with smaller Health Service Providers to assist in developing their increasing capacity for quality improvement.
- For some smaller Health Service Providers, move to accreditation may require resources beyond their capacity to support. Mitigation:
  - o LHIN will work with Health Service Providers to support accreditation efforts.
- Access to appropriate data for measuring and reporting on improvement. Mitigation:
  - o LHIN will continue to work with various available data sources and with Health Service Providers to obtain, review and utilize data as appropriately as possible.

## Key Enablers that Will Allow the LHIN to Achieve its Goals

- Alignment and coordination of strategies related to quality to optimize the impact of improvement efforts.
- Leadership for quality at all levels across the Central West LHIN and the Health Service Providers.
- Strong and on-going engagement with all Health Service Providers regarding the quality agenda and support for opportunities to build capability and capacity through learning, application and exchange.
- Maximizing provincial, regional and local Health Service Providers' expertise and resources to advance a culture for continuous quality improvement.
- Planning for spread and sustainability.

# Drive Quality & Value

## Optimize use of health care resources to foster better value for money

### IHSP Initiative Description

The LHIN will reduce avoidable hospital admissions by supporting expanded community-based services. The LHIN will reduce Alternate Level of Care (ALC) designations by seeking improvements in discharge processes and supporting community-based services. The LHIN will work with local providers on the improvement of admission, bed utilization, and discharge processes. Additionally, the LHIN will implement Health System Funding Reform initiatives with the Ministry of Health and Long-Term Care and local Health Service Providers to support best practice, cost-effective treatment and care.

### Current Status

#### Avoidable Hospital Admissions

- The Central West LHIN consistently has the highest proportion of high-acuity emergency department (ED) visits in the province, which means that a substantial number of those patients are likely to require admission to an inpatient bed.
- Nonetheless, there are still patients admitted to inpatient beds whose admission could have been avoided if they had been linked with appropriate community-based services either before the event that led to their ED visit, or while at the ED.
- These patients, when admitted, are at a high risk of being designated ALC early in their inpatient stay.
- In 2011-12, 13% of ED visits in the Central West LHIN resulted in an inpatient admission (compared to 11% for the province), and 75% of the high acuity ED visits resulted in an inpatient admission (compared to 63% for the province).

#### Strategies

- Reduce avoidable hospital admissions by linking individuals with appropriate community-based services.
- Reduce Alternate Level of Care (ALC) days by improving discharge processes and supporting alternate community-based services.
- Improve admission, bed utilization, and discharge processes through education and communication.
- Implement Health System Funding Reform initiatives with the Ministry of Health and Long-Term Care and local Health Service Providers.

#### Alternate Level of Care (ALC)

- When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting, the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies). Patients designated ALC are, by definition, not receiving the care they need, and they are also taking up a resource (the inpatient bed) that is needed by another patient, usually one waiting in the emergency department. The number of patients being processed through the system without being designated ALC continues to increase, while the number of patients being discharged with an ALC designation continues to decrease. However, because there is no additional capacity to discharge patients to, the patients who are designated ALC are waiting longer, and therefore accumulating more ALC days. In 2012, 1,998 patients were designated ALC in the Central West LHIN, and accumulated a total of 38,294 ALC days, representing a substantial opportunity for improvement. Providing appropriate services in the community for those patients who are able to be discharged at the end of their acute or post-acute phase of treatment will both meet their needs better, and will free up badly-needed resources within the hospital.

### Patient Flow Process Improvement

- The opportunity for improving the health care system is greatest at its points of transition. These opportunities for improvements at handoffs between providers, and even between different aspects of the same provider, result in avoidable escalations of care. A contributing factor is inefficient or sometimes absent processes for transitions. A proven process improvement methodology, such as LEAN, can identify many opportunities for improvement, from “low hanging fruit” to more difficult long-term changes, that will result in more appropriate use of health care resources, reduced waste, and better patient experience.

### Health System Funding Reform (HSFR)

- In January 2012, the government introduced Ontario’s Action Plan for Health Care. A component of this plan is to drive processes that will result in better value from our health care dollars. Health System Funding Reform is moving Ontario’s health care system away from a global funding system towards what is known as Patient-Based Funding (PBF). Under PBF, health care organizations are compensated based on how many patients they look after, the services they deliver, the evidence-based quality of those services, and the specific needs of the broader population they serve.

## Consistency with Government Priorities

### Avoidable Hospital Admissions

- A consistent theme of the Action Plan for Health Care is to move care into the community to avoid unnecessary escalation of level of care. In addition, preventing avoidable hospital admissions will increase the efficiency of resource allocation.

### Alternate Level of Care

- Reduction of ALC has been a provincial priority since the inception of the provincial ER/ALC strategy in 2009.

### Patient Flow Process Improvement

- Improving patient flow and reducing barriers will result in more patients receiving the care they need, when and where they need it. It will also result in better value for money.

### Health System Funding Reform

- Inherent in the implementation of HSFR is a major change management strategy that requires action from all levels – Provider (local), Regional (LHIN) and Systems.
- The Ministry of Health and Long-Term Care and the 14 LHINs are establishing Local Partnerships to help foster the change management environment for HSFR across Ontario.

| Action Items / Interventions | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Working with Health Service Providers under projects to optimize patient flow. | In progress 20% | 20% | 20% |
| Implement local Health System Funding Reform Partnership. | Not yet started 100% | | |
| Ensure local alignment to annual Provincial HSFR Roll-Out. | Not yet started 100% | | |
| Create a multi-phased capacity plan by sector, using a demographic and utilization evidenced based methodology. | Not yet started 25% | 50% | 25% |

## Expected Impacts of Key Action Items (How We Will Measure Success)

- Meeting MLPA target for Wait time indicators.
- Meeting MLPA target for 90th Percentile ER length of stay for non-admitted Complex (CTAS I-III).
- Meeting MLPA target for re-admission with 30 days for selected case mixed group.
- Meeting MLPA target for 90th Percentile ER length of stay for admitted patients.

## Risks/Barriers to Successful Implementation

- LHIN resources inadequate to support HSFR implementation. Mitigation:
  - LHIN management team to ensure adequate resources applied to initiative.
- Professional staff at Health Service Providers does not embrace Quality Based Procedures best practice, lack of implementation of change plans, reversion to old ways of doing things.
  - part of change management process needing management by Health Service providers and LHIN leadership teams

## Key Enablers that Will Allow the LHIN to Achieve its Goals

- Clear identification of each process, with clear timelines, objectives, and accountabilities.
- Consistent application of change management methodologies.
- Strong senior management buy-in and support at all involved HSP's and at LHIN.
- Allocation of sufficient time and resources for staff engagement, training, and internalization.
- Commitment of all staff to supporting change and sustainability.
- Ministry of Health and Long-Term Care HSFR Planning On-Track – flexibility to adjust implementation both locally and provincially.
- Local understanding of HSFR and funding processes – HBAM; QBPs; LTCH – CMI etc.
- Local providers - including professional staff - embrace required changes necessary to align with HSFR strategies.
- Local collaboration from a systems perspective.
- Adequate LHIN resources to support HSFR implementation.

# Build on the Momentum

The LHIN will continue to devote attention and resources to initiatives in keeping with the LHIN's legislated requirements and that continue to be identified through community engagement and priority-setting, aligned with developing provincial directions and priorities.

The Central West LHIN will continue engaging with the community and Health Service Providers to improve access to local services in the following areas:

- Aboriginal Health
- Diversity and Health Equity
- French Language Services
- Palliative Care Services
- Women and Children's Health.

## IHSP Initiative Description

### Aboriginal Health

- The Central West LHIN will meet its legislated requirements to engage with local Aboriginal and First Nations peoples to better understand local health and service delivery issues and develop priorities and strategies to improve engagement and access to health care services.

### Diversity and Health Equity

- The Central West LHIN will work with local Health Service Providers at the Diversity and Health Equity Core Action Group to identify specific local strategies to engage the diverse communities in the LHIN and to promote equitable access to health care services. This work will include identifying key priorities for action, utilizing tools such as the Health Equity Environmental Scan, the Health Equity Impact Assessment Tool (HEIA), Health Equity Plans, and focusing on culturally competent approaches that improve access to, and the quality of, health care services.

### French Language Services

- The Central West LHIN will meet its legislated requirements for coordinated and effective engagement of local French-speaking communities by working in collaboration with Reflet Salvéo, to foster a French Language Services (FLS) lens across strategic directions to improve access to, and integration of, French language health care services in the local health care system.
- This work will include the monitoring of FLS indicators by Health Service Providers identified for FLS and the implementation of action plans towards the establishment of FLS in the Primary Care and Mental Health & Addictions sectors, in order to build towards the establishment of a FLS continuum of care.

#### Strategies

- Consult with the community to gather perspectives on local healthcare services
- Continue to engage with health service providers to develop strategies the improve equitable access for all residents
- Build cross-sector partnerships to ensure a collaborative approach to improve access and quality of care for marginalized and vulnerable populations
- Apply FLS Lens consistently across Health Care Planning.

### Palliative Care Services

- Along with LHINs across the province and the Ministry of Health and Long-Term Care, and working locally with the Central West Palliative Care Network, the Central West LHIN will participate in the development of the vision for palliative care in the province and will establish the local plan for palliative care services, tailored to meet the needs of residents in the Central West LHIN.

### Women and Children's Health

- The Central West LHIN will work with local providers to improve access to and the quality of women and children's health services aligning its work with provincial initiatives.

## Current Status

- There is a smaller Aboriginal population in the Central West LHIN (0.6%) compared to the province (2.0%) - the number of Aboriginal residents in the LHIN being 5,890 (2006 Census). Members of the Aboriginal community currently seek health and social services through mainstream providers or travel to Toronto to seek culturally-sensitive services through Anishnawbe Health.

- The LHIN conducted a Health Equity Scan across the region leading to the development of key areas of focus for the LHIN and the Diversity and Health Equity Core Action Group. The LHIN has rolled out the Health Equity Impact Assessment tool to all providers by partnering with the Ministry of Health and Long-Term Care and the Regional Diversity Roundtable.

- In collaboration with Reflet Salvéo (the French Language Planning Entity), a Central West LHIN French Language Service Mapping is being developed, presenting all health-related services available in French in the Central West LHIN.

- The Central West Palliative Care Network provides a community of interest for the advancement of hospice palliative care. Network members benefit from a system of communications, strategic planning, and education through a Steering Committee and advisory groups. Members represent the hospice palliative care, hospital, long-term care, primary care, community care and education sectors. The Network has introduced the first elements of a Shared Care Model of hospice palliative care with Advanced Practice Nurses.

- The Central West LHIN is home to the highest birth rate in the province. The crude birth rate is 13.8 per 1000 population. The LHIN conducted eight community engagement sessions with women from diverse backgrounds about their perspective on local health care services and needs. Feedback from women were compiled and summarized and has assisted the LHIN and the Women and Children's Health Core Action Group to take a regional/systems approach to identifying strategies that improve access to health services and health outcomes for all women in the region.

## Consistency with Government Priorities

Planning for the local needs of Aboriginal communities will build upon work being done at the provincial level, including the development of the Aboriginal and First Nations Health Council, the provincial Aboriginal Wellness Strategy, and the Aboriginal Diabetes Strategy.

The provision of health services in French is mandated by the French Language Services Act (FLSA) and the Local Health System Integration Act (LHSIA).

The Central West LHIN recognized the cultural diversity and the vulnerable populations in the LHIN and will ensure a Health Equity perspective is built into the planning, funding and implementation of programs. This is in alignment with the goals of the Ministry of Health and Long-Term Care's strategic directions of access and equity of access, which are outlined in the Local Health System Integration Act.

The goals of the Central West Palliative Care Network are aligned with the desired standards as detailed in the Ministry of Health and Long Term Care document: "Advancing High Quality, High Value Palliative Care in Ontario, Declaration of Partnership and Commitment to Action" (2011). The Central West LHIN will work with the Central West Palliative Care Network to develop a full continuum of hospice palliative care services which ensures seamless delivery linked by common practice, process structures and education.

The Central West LHIN will work with the Provincial Council for Maternal Child Health (PCMCH) to ensure the roll out of best practices and the ongoing engagement necessary to ensure a provincial approach to recognizing and closing the gaps in healthcare as it pertains to women and children.

| Action Items / Interventions | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Engage local and Aboriginal First Nation community to inventory local health care services viewed as meeting local needs of Aboriginal and First Nations health care in a culturally competent manner. | In progress 34% | 33% | 33% |

| Action Items / Interventions | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| All health service providers to do 3 to 5 year health equity plan | Not yet started 50% | 50% | |
| Develop and implement a Language Interpretation Model for community sector service providers and hospitals. | Not yet started 100% | | |
| In collaboration with Reflet Salvéo and partnering LHIN's, implement LHIN specific action items from the French Language Services (FLS) Joint Annual Action Plan, which outlines objectives and priorities for engaging the francophone community and for planning & implementing services on an annual basis | In Progress 100% | | |
| Develop FLS capacity in Central West Health Service Providers through an enhanced active offer of services, specifically in the Mental Health & Addictions and Primary Care sectors | In Progress 34% | 33% | 33% |
| Implement the Shared Care Model of Palliative Care | In Progress 50% | 50% | |

## Expected Impacts of Key Action Items (How We Will Measure Success)

### Aboriginal Health

- Complete inventory of Aboriginal and First Nations health care services.

### Diversity and Health Equity

- Share cultural competency resources with all Health Service Providers.
- All Health Service Providers have access to Language Interpretation Services.
- Health Equity Impact Assessment applied to all LHIN planning initiatives.

### French Language Services

- With neighbouring LHINs and Reflet Salvéo, establish annual French Language Services Joint Annual Action Plan (JAAP), which presents specific and measurable performance indicators for each action item identified in the Plan.
- Two new FLS indicators will be introduced in 2013-14 for Health Service Providers identified for FLS, as part of their quarterly reporting to Central West LHIN. For the first year, an upward trend for both indicators, from one quarter to another, will be considered a positive result.

### Palliative Care Services

- Incorporate the 5 newly funded nurse practitioners into the Shared Care Model and add additional personnel as funding permits (e.g. psychosocial provider, medical advisor).
- Double the number of programs offered and physicians attending hospice palliative care education sessions (e.g. Learning Essential Approaches to Palliative and End of Life Care).
- Increase the number of Emergency Department visits averted by community-based palliative patients by 5%.
- Double the number of sessions offered in advanced care planning.

### Women and Children's Health

- Complete local plan for children with medical complexity.

## Risks/Barriers to Successful Implementation

### Aboriginal Health

- Local Aboriginal First Nations people are not fully engaged in LHIN activities, in part because of the size and visibility of the local population and in part because of its orientation into Toronto-based Aboriginal Health Service Providers.

### Diversity and Health Equity

- Service pressure based on population growth and need may deflect attention away from specific needs of communities.
- Lack of reliable data on the use of health care services by members of diverse communities limits local specific knowledge about utilization of services by diverse ethno-cultural populations.

### French Language Services

- Distinct priorities between partners may delay the achievements of certain action items.
- Identified Health Service Providers do not request the information from new clients in a consistent manner; Francophones do not identify themselves as wanting their services in French due to perception of non-availably of French language services.

### Palliative Care Services

- There is a lack of palliative-care trained health care professionals.
- The aging population will increase the need for palliative services.

### Women and Children's Health

- Identified best practices and improved local model of care for children with medical complexity may require LHIN investment. Such capacity/resource limitations need to be discussed at a local and provincial level.

## Key Enablers that Will Allow the LHIN to Achieve its Goals

### Aboriginal Health

- Meeting with local representatives from the Aboriginal and First Nations community (Peel Aboriginal Network) to engage and provide input and feedback on LHIN activities.

### Diversity and Health Equity

- Engaging Health Service Providers by identifying champions and those with key interests through a forum like the Diversity and Health Equity Core Action Group allows for increased acceptance and engagement to improve health equity.
- Conducting community engagement sessions with identified marginalized populations to understand the struggles of those that have difficulties accessing health care services will ensure the LHIN is always building in processes and strategies to meet the needs of the most vulnerable. Such processes will ensure there is equitable access for all.
- Linking with other government sectors that also have a Diversity and Health Equity focus will ensure efficiencies in regional and cross-sectoral strategies (e.g. leveraging SickKids Cultural Competence training funded by Citizenship and Immigration Canada).

### French Language Services

- Strong leadership, efficient planning process and clear communication protocols within the LHIN's/Reflet Salvéo partnership will create the favorable environment required to translate the FLS Joint Annual Action Plan into concrete results.
- Inclusion of the FLS lens in new service models, such as Health Links, and in initiatives related to the Mental Health & Addictions' 10-year strategy, such as service collaboratives, will be key to increasing FLS capacity. Active engagement of the FLS Core Action Group regarding the new FLS indicators will be important to ensure proper progress measurement.

### Palliative Care Services

- Strong leadership of the Central West Palliative Care Network enhances cooperation amongst partners.
- The engagement of diverse communities in palliative care awareness will improve services to this population.

### Women and Children's Health

- Engaged and dedicated regional stakeholders to identify the best model for the region. This will also ensure successful engagement and implementation.

# Staffing and Operations

| Staffing | | | | | |
|---|---|---|---|---|---|
| **Position Title** | **2011/12 Allocation FTEs** | **2011/12 Actuals FTEs** | **2012/13 Forecast FTEs** | **2013/14 Forecast FTEs** | **2014/15 Forecast FTEs** |
| CEO | 1 | **1** | 1 | 1 | 1 |
| Senior Director | 2 | **2** | 2 | 2 | 2 |
| Executive Assistant | 2 | **2** | 2 | 2 | 2 |
| Administrative Assistant | 2 | **2** | 2 | 2 | 2 |
| Board and CEO Liaison | 1 | **1** | 1 | 1 | 1 |
| Director, Health System Integration | 4 | **4** | 4 | 4 | 4 |
| Director, Funding and Allocation | 2 | **2** | 2 | 2 | 2 |
| Director, Performance & Accountability | 1 | **1** | 1 | 1 | 1 |
| Director, Quality | 1 | **1** | 1 | 1 | 1 |
| Director, Communication and Community Engagement | 1 | **1** | 1 | 1 | 1 |
| Director, ER/ALC/Decision Support | 1 | **1** | 1 | 1 | 1 |
| Specialist, Performance & Quality | 1 | **1** | 1 | 1 | 1 |
| Specialist, Integration/Performance/Quality | 1 | **1** | 1 | 1 | 1 |
| Specialist, Decision Support | 1 | **1** | 1 | 1 | 1 |
| LHIN Operations Manager | 1 | **1** | 1 | 1 | 1 |
| Performance Specialist | - | **-** | - | 1 | 1 |
| Director, Health System Integration (Diabetes Regional Coordination Centre) | - | **-** | 1 | 1 | 1 |
| Administrative Assistant (Diabetes Regional Coordination Centre) | - | **-** | 1 | 1 | 1 |
| Outreach Coordinator (Diabetes Regional Coordination Centre) | - | **-** | 2 | 2 | 2 |
| Specialist, Decision Support (Diabetes Regional Coordination Centre) | - | **-** | 1 | 1 | 1 |
| French Language Services Coordinator | 1 | **1** | 1 | 1 | 1 |
| **Total FTEs** | **23** | **23** | **28** | **29** | **29** |

| LHIN Operations Spending Plan | | | | | |
|---|---|---|---|---|---|
| **LHIN Operations Sub-Category ($)** | **2011/12 Allocation** | **2011/12 Actuals** | **2012/13 Planned Expenses** | **2013/14 Planned Expenses** | **2014/15 Planned Expenses** |
| **Salaries and Wages** | 2,286,295 | 2,180,963 | 2,188,004 | 2,304,489 | 2,304,489 |
| **EMPLOYEE BENEFITS** | | | | | |
| HOOPP | 228,630 | 209,325 | 217,615 | 230,449 | 230,449 |
| Other Benefits | 246,734 | 253,423 | 240,356 | 253,495 | 253,495 |
| ***Total Employee Benefits*** | ***475,364*** | ***462,748*** | ***457,971*** | ***483,944*** | ***483,944*** |
| **TRANSPORTATION AND COMMUNICATION** | | | | | |
| Staff Travel | 34,000 | 29,798 | 30,000 | 30,000 | 30,000 |
| Governance Travel | 25,000 | 13,397 | 20,000 | 20,000 | 20,000 |
| Communications | 75,000 | 41,385 | 65,000 | 65,000 | 65,000 |
| Other | 25,000 | 33,509 | 34,584 | 30,000 | 30,000 |
| ***Total Transportation and Communication*** | ***159,000*** | ***118,089*** | ***149,584*** | ***145,000*** | ***145,000*** |
| **SERVICES** | | | | | |
| Accommodation | 235,440 | 255,406 | 241,381 | 240,000 | 240,000 |
| Advertising | 20,000 | 15,660 | 20,000 | 20,000 | 20,000 |
| Banking | 100 | 108 | 100 | 100 | 100 |
| Consulting Fees | 340,000 | 249,070 | 297,628 | 191,000 | 191,000 |
| Equipment Rentals | 7,769 | 9,025 | 8,500 | 8,500 | 8,500 |
| Insurance | 23,000 | 20,692 | 7,000 | 7,000 | 7,000 |
| LSSO Shared Costs | 359,000 | 475,025 | 342,000 | 342,000 | 342,000 |
| LHIN Collaborative | 50,000 | 26,970 | 47,500 | 47,500 | 47,500 |
| Other Meeting Expenses | 30,000 | 28,074 | 25,000 | 25,000 | 25,000 |
| Board Chair's Per Diem Expenses | 80,000 | 60,900 | 72,800 | 72,800 | 72,800 |
| Other Board Members' Per Diem Expenses | 90,000 | 78,650 | 84,500 | 84,500 | 84,500 |
| Other Governance Costs | 40,000 | 17,294 | 24,000 | 24,000 | 24,000 |
| Printing and Translation | 35,960 | 46,999 | 45,000 | 45,000 | 45,000 |
| Staff Development | 60,000 | 38,195 | 45,000 | 45,000 | 45,000 |
| ***Total Services*** | ***1,371,269*** | ***1,322,068*** | ***1,261,408*** | ***1,152,400*** | ***1,152,400*** |
| **SUPPLIES AND EQUIPMENT** | | | | | |
| IT Equipment | 35,000 | 17,281 | 20,000 | 20,000 | 20,000 |
| Office Supplies & Purchased Equipment | 50,000 | 57,580 | 49,995 | 49,995 | 49,995 |
| ***Total Supplies and Equipment*** | ***85,000*** | ***74,861*** | ***69,995*** | ***69,995*** | ***69,995*** |
| **Capital Expenditures** | 25,000 | 6,780 | 25,000 | 25,000 | 25,000 |
| **LHIN Operations: Total Planned Expense** | **4,401,928** | **4,165,509** | **4,151,962** | **4,180,828** | **4,180,828** |
| **Annual Funding Target** | | 4,368,968 | 4,180,828 | 4,180,828 | 4,180,828 |
| **Surplus** | | 203,459 | 29,866 | - | - |

| INITIATIVES SPECIFIC FUNDING | | | | | |
|---|---|---|---|---|---|
| French Language Services | 106,000 | 89,632 | 75,606 | 106,000 | 106,000 |
| **Annual Funding Target** | 106,000 | 106,000 | 106,000 | 106,000 | 106,000 |
| **French Language Services Surplus** | - | 16,368 | 30,394 | - | - |
| Diabetes Regional Coordination Centre | - | - | 192,817 | 993,401 | 993,401 |
| **Annual Funding Target** | - | - | 192,817 | 993,401 | 993,401 |
| **Diabetes Regional Coordination Centre Surplus** | - | - | - | - | - |
| Aboriginal Community Engagement | 7,500 | - | 2,500 | 7,500 | 7,500 |
| **Annual Funding Target** | 7,500 | 7,500 | 7,500 | 7,500 | 7,500 |
| **Aboriginal Community Engagement Surplus** | - | 7,500 | 5,000 | - | - |

# ABP Communications Plan

## Objectives

### Business Objective

The Annual Business Plan (ABP) is a key component of the Ministry / LHIN accountability framework. By drawing on the four strategic directions of the Central West LHIN IHSP 3, the ABP will provide a detailed implementation of the work that the Central West LHIN will undertake for the upcoming fiscal year 2013/2014.

### Communications Objective

Increase the profile and value of the LHINs by promoting the Annual Business Plan as the working document outlining the LHIN's activities to improve local health care services for the fiscal year 2013/2014. Measurements will be gaged based on stakeholder participation at events and meetings.

## Context

The Central West LHIN develops an ABP to outline in detail, key actions the LHIN intends to take in 2013/2014. It outlines the expected impacts of these key action items that falls under the LHIN's strategic directions identified in the IHSP 3. The ABP also provides overall goals and specific objectives for spending the upcoming year's funding allocation.

The Central West LHIN established its Strategic Communication Framework, which laid out common themes, key audiences, narratives and tactics to ensure the LHIN's messages are communicated in a strategic and purposeful way. Recently the LHIN established itsIHSP3 Communications Plan. This plan's objective is to ensure all local audiences in the Central West LHIN are aware of the IHSP 3, its strategic directions and initiatives from 2013 - 2016, as well as to re-iterate the value of the LHIN and the IHSP 3 to local residents. The ABP Communications Plan will align with these plans and with the Province's Action Plan for Health Care.

## Target Audience/Stakeholders

### Primary

- Public (taxpayers, patients/clients and family members)
- Health Service Providers, community partners and primary care providers
- Local government stakeholders (MPPs, regional, municipal officials)
- Ministry of Health and Long-Term Care

### Secondary

- Media

## Strategic Approach

Messaging about the ABP will be implemented throughout the Central West LHIN's various communications vehicles moving forward. Reference to the specific goals as outlined in the ABP will be made using the tactics outlined below.

## Tactics

Once approved by the Ministry of Health and Long-Term Care, the following tactics will be implemented to publicize the ABP:

- Post on website.
- Promote to stakeholders via email with link to website and soft copy of ABP.
- Discuss at HSP events, community partner events.
- Discuss at MPP and municipal meetings and presentations.

- Discuss at Board to Board meetings.
- Discuss at Governance leadership forums.
- Promote in news releases and related communications products.

### Key Messages

The Central West LHIN's Annual Business Plan will outline the actions that will be undertaken to implement the Integrated Health Services Plan (IHSP 3).

The Central West LHIN's Annual Business Plan draws on the four strategic directions of the IHSP 3 to improve local health care services in 2013/2014.

The Annual Business Plan is a working document that will be used by the Central West LHIN to improve local health care services for 2013/2014.

*C'est pour vous*
*C'est pour votre santé!*

# Central West **LHIN**

## Contact Information

Telephone: 905-455-1281
Toll Free: 1-866-370-5446
Fax: 905-455-0427

8 Nelson Street West, Suite 300
Brampton, Ontario
L6X 4J2

www.centralwestlhin.on.ca

# **RLISS** du Centre-Ouest

## Coordonnées

Téléphone: 905-455-1281
Sand frais: 1-866-370-5446
Télécopieur: 905-455-0427

8, rue Nelson Ouest, bureau 300
Brampton, Ontario
L6X 4J2

www.centralwestlhin.on.ca

*It's about you*
*and your health!*

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé