Central West **LHIN**

ANNUAL BUSINESS PLAN 2016-2017

Making HEALTHY Change Happen

Ontario
Local Health Integration Network

CONTENTS

GLOSSARY

The following glossary provides quick reference to the most commonly used acronyms throughout this document.

ABP	Annual Business Plan
ALC	Alternate Level of Care
BCH	Brampton Civic Hospital
CAG	Core Action Group
CCAC	Community Care Access Centre
CCO	Cancer Care Ontario
CDPM	Chronic Disease Prevention and Management
CHC	Community Health Center
CSS	Community Support Service
CWPCN	Central West Palliative Care Network
ED	Emergency Department
EGH	Etobicoke General Hospital
EMR	Electronic Medical Record
FHG	Family Health Group
FHO	Family Health Organization
FHT	Family Health Team
FLS	French Language Service(s)
H2H	Hospital to Home
HHCC	Headwaters Health Care Centre
HIP	Home Independence Program
HRM	Hospital Report Manager
HSP	Health Service Provider
HQO	Health Quality Ontario
IAR	Integrated Assessment Record
IDEAS	Improving and Driving Excellence Across Sectors
IHSP	Integrated Health Service Plan
IM	Information Management
IT	Information Technology
LHIN	Local Health Integration Network
LHSIA	Local Health System Integration Act
LTC	Long-Term Care
MOHLTC	Ministry of Health and Long-Term Care
OPOC	Ontario Perception of Care
OTN	Ontario Telemedicine Network
REACH	Rapid Electronic Access to Clinical Health
SAM	System Access Model

A Message from the Board Chair & CEO

The Central West Local Health Integration Network (LHIN) is pleased to present its 2016/17 Annual Business Plan (ABP 2016/17) for the fiscal year beginning April 1, 2016 and ending March 31, 2017.

Each year the LHIN develops a formal business plan that identifies specific activities designed to support the implementation of its three-year strategic plan, more commonly referred to as an Integrated Health Service Plan (IHSP). Accordingly, ABP 2016/17 identifies specific activities that support the first year of IHSP 2016-2019.

Rooted in the common vision and priorities of Ontario's *Patients First:* Action Plan for Health Care, and the common objectives of Ontario's 14 LHINs, IHSP 2016-2019 outlines the next phase of the LHIN's commitment and actions to transform the local health care system into one that meets the complex health care needs of a rapidly growing, aging and culturally diverse population. Ambitious yet actionable, and flexible in its ability to adapt to the changing needs of the health care environment, it is a shared strategic document that describes how, together with Health Service Providers (HSPs) and community partners, the Central West LHIN intends to plan, fund, integrate and monitor the local health care system for the three-year period April 1, 2016 to March 31, 2019.

An extension of IHSP 2016-2019, ABP 2016/17 places the needs of patients first by focussing on those specific activities the LHIN will undertake to advance each of its four strategic directions: *Build Integrated Networks of Care, Drive Quality and Value, Connect and Inform, and Demonstrate System Leadership.* Specific attention is given to the current status of each, activities to be completed during the coming fiscal year, the impact these initiatives/activities will have on the local health care system, and performance measures used to gauge LHIN success. ABP 2016/17 also includes an overview of plans related to operations (finance and staffing) and communications/community engagement.

While, over the past decade, Ontario's health care system has improved significantly, there are a number of areas where we need to do more; particularly when it comes to achieving a genuinely integrated health system. It follows that the Central West LHIN remains committed to improving

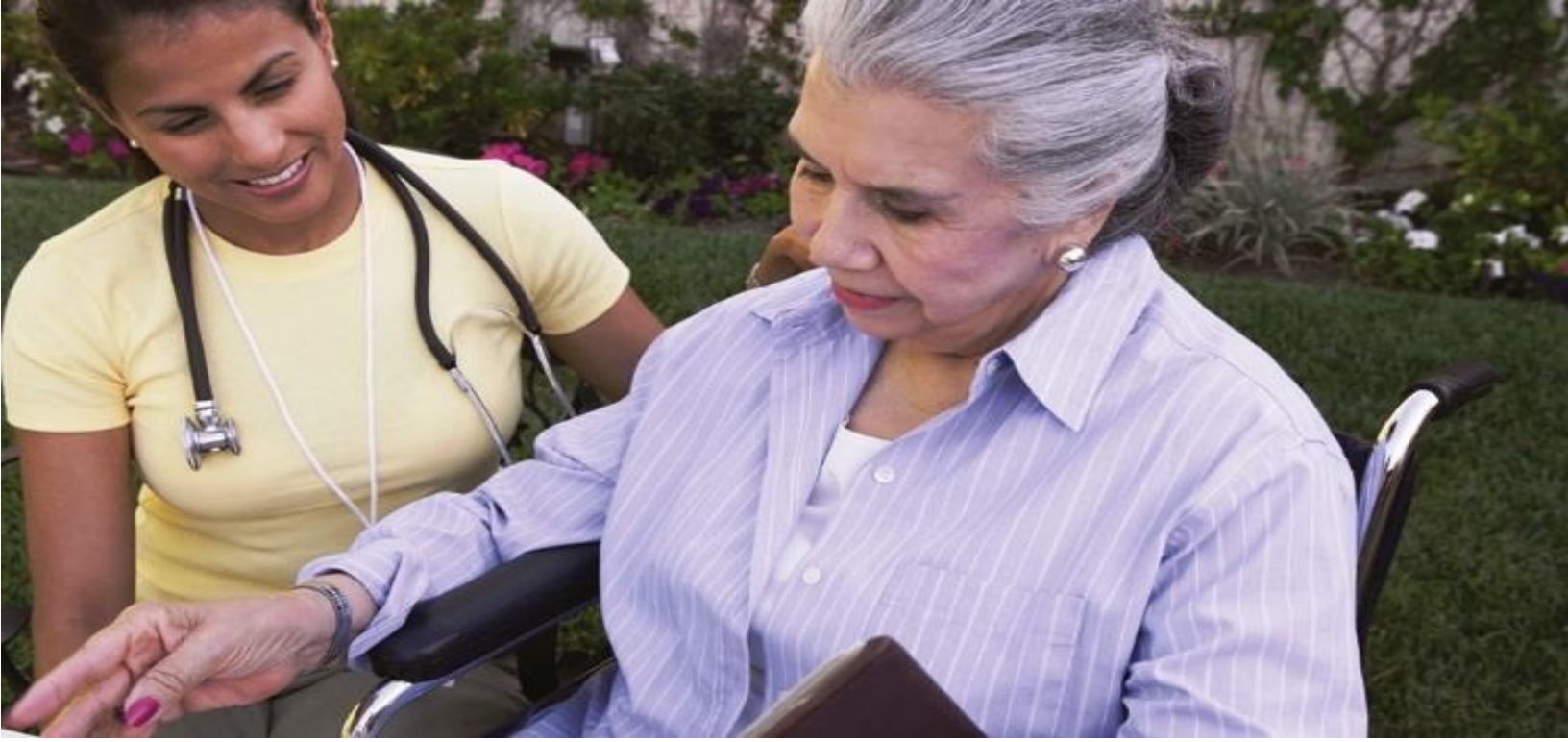
access, connecting services, supporting people and patients, and protecting the local health care system both now and for future generations. Nevertheless, one thing is certain. Past and future gains can and will be attributed to the strong, collaborative relationships that exist between the LHIN and a highly engaged group of HSPs and community partners.

Both residents and health care professionals alike place high value on their health care system and its need to be responsive to local communities. The LHIN's Board of Directors and staff thank HSPs and community partners who have taken ownership and accountability for meaningful change, and local residents who continue to play an active role in shaping their local health care system. Collectively, this ongoing dedication and commitment toward the provision of high-quality, patient-centred health care is transforming a bold vision into reality.

Together, Making Healthy Change Happen

Maria Britto
Board Chair

Scott McLeod
CEO



Overview

Annual Business Plan 2016/17 (ABP 2016/17) is the Central West Local Health Integration Network's (LHIN's) work plan for fiscal year April 1, 2016 through March 31, 2017. It identifies specific activities that support the first year of Integrated Health Service Plan 2016-2019 (IHSP 2016-2019).

An extension of IHSP 2016-2019, ABP 2016/17 places the needs of patients first by focussing on those specific activities the LHIN will undertake to advance each of its four strategic directions: *Build Integrated Networks of Care, Drive Quality and Value, Connect and Inform, and Demonstrate System Leadership.*

ABP 2016/17 is divided into four main sections:

Section 1 | Context... Provides an overview of the Central West LHIN's mandate, strategic directions, and provincial alignment. It also includes an environmental profile (population and health) of local residents, a summary of current LHIN activities, and an assessment of potential challenges to the local health care system.

Section 2 | Core Content... Outlines activities the Central West LHIN will undertake in 2016/17 to support the strategic directions of IHSP 2016-2019[1]. Included in this section are performance measures and targets that will be used to measure progress, and an understanding of potential risks/barriers to successful implementation.

Section 3 | LHIN Operations... Provides a three-year spending plan for Central West LHIN operations, including a summary of current and proposed staffing levels.

Section 4 | Communications and Community Engagement... Describes Central West LHIN communications and community engagement goals, objectives and evaluation measures for the coming fiscal year.

The success of ABP 2016/17 will be documented in the Central West LHIN's 2016/17 Annual Report, which looks back on work accomplished to chronicle how the LHIN's activities placed patients first, ensuring the needs of LHIN residents remained at the centre of their local health care system.

In partnership with the Ministry of Health and Long-Term Care (MOHLTC), health service providers (HSPs), community partners, and local residents, the Central West LHIN is working to ensure a sustainable, high-quality, and person-centred local health care system for current and future generations.

[1]Per MOHLTC guidelines, the status of work (Not Yet Started, In Progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years. Percentages may not equal 100% due to work completed in previous fiscal calendar years, or work that is expected to carry forward beyond fiscal year 2018/19.

Context

The Central West Local Health Integration Network (LHIN) was established under the *Local Health System Integration Act (LHSIA) - 2006*, and given the authority to plan, fund, integrate and monitor the local health care system for the purpose of improving the health of residents who live in communities within its geographic boundaries including Brampton, Caledon, Dufferin County, Malton, north Etobicoke, and west Woodbridge.

Mission

For the Central West LHIN to drive change it must remain committed to its mission. The mission represents the LHIN's core responsibility, and is the focal point for how the LHIN will achieve its vision:

To improve access to, and the quality of, health services for residents of the Central West LHIN, through strengthened integration and coordination of health services.

Vision

Based on Ontario's *Patients First*: Action Plan for Health Care, the Central West LHIN's vision represents its aspirations for the local health care system:

"Residents of the Central West LHIN will have better and faster access to high-quality health services. They will have better information so they can make decisions that will help them live and stay healthy. Their services will be protected to ensure they are sustainable for future generations."

Values

As the Central West LHIN works to achieve its mission and vision, its actions and decisions are underpinned and grounded in a set of core values:

Person-Centred Care: With purpose and passion, we work with individuals and the community to advance the public good, and we place people and patients first, ensuring the needs of LHIN residents remain at the centre of their local health care system.

Transparency: A commitment to the highest possible ethical standards, and open and timely sharing of information.

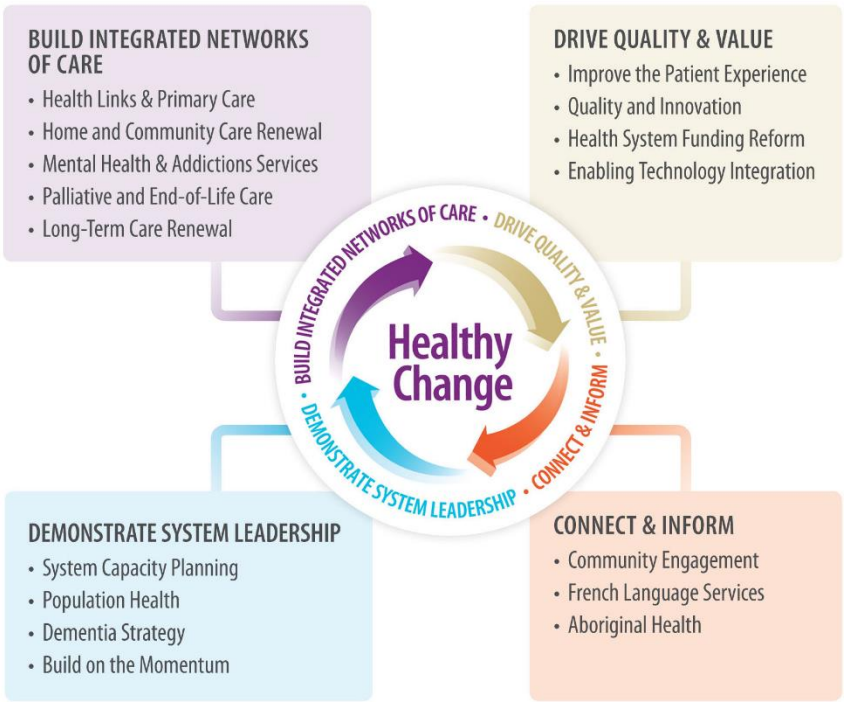
Integrity: In all of our activities, we will foster trust by being truthful, empathetic and consistent.

Stewardship: In managing all resources for which we have been entrusted, we will seek ways to ensure appropriate use of resources, and act responsibly, taking actions that align with our vision, values and strategic directions.

Meeting the complex health care needs of a rapidly growing, aging and culturally diverse population - like that of Central West LHIN - requires smart, local planning. It also requires an ability to address broader provincial priorities.

The LHIN's strategic directions and initiatives, outlined in IHSP 2016-2019 and operationalized in ABP 2016/17, are rooted in the common vision and priorities of Ontario's *Patients First:* Action Plan for Health Care, *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario, *Patients First*: A Roadmap to Strengthen Home and Community Care and the objectives of Ontario's 14 LHINs.

IHSP 2016-2019 Strategic Directions and Initiatives



The Central West LHIN Landscape

Population Profile

The Central West LHIN has grown substantially over the last decade, from 740,000 residents in 2006 to over 922,000 currently (seven percent of Ontario's population). With the highest projected growth rate in the province – over 17,000 new residents each year – the LHIN's population is expected to grow to almost 1.1 million by 2025. Not only is the Central West LHIN's population growing, it is aging. By 2025, the population of seniors (those aged 65 or more) is expected to increase by 62%, from 111,000 to 180,000.

One of the most geographically and ethnically diverse LHINs in the province, 86% of LHIN residents reside in urban areas, 7% in a suburban setting, and 7% in rural communities. 47% of residents of the LHIN are immigrants – seven percent of whom are new to Canada within five years, and slightly over half of whom report English as their mother tongue, the second lowest rate in the province. The LHIN is also home to over 14,000 francophone residents and 5,600 residents who self-report as aboriginal people.

Over the past five years, notable investments have improved access to a variety of health care programs and services in the Central West LHIN. In collaboration with HSPs and community partners, the LHIN remains committed to the planning, development and delivery of innovative and creative health care programs and services that meet the current and future needs of LHIN communities.

Health Profile and Access to Care

Timely and appropriate access to primary health care is a key objective of Ontario's *Patients First:* Action Plan for Health Care and IHSP 2016-2019. While almost all (93%) of LHIN residents report having a regular primary care provider, only 57% report the ability to see a primary care provider on the same or next day when sick. These indicators are particularly important for the Central West LHIN's population given the prevalence of certain chronic conditions and premature mortality.

Between 2009 and 2013 the proportion of Central West LHIN residents with at least one chronic condition decreased, and is significantly lower than the province. Prevalence decreased for every chronic condition, with the exception of chronic obstructive pulmonary disease (COPD). The prevalence rate of COPD doubled in the Central West LHIN, from 2.1% to 5.0%, while Ontario's rate remained stable. Although the prevalence of diabetes has decreased in the Central West LHIN, the prevention and management of diabetes will continue to remain a local priority given the unique blend of an unprecedented growth in the seniors population combined with higher proportions of high risk ethnic groups residing within the Central West LHIN.

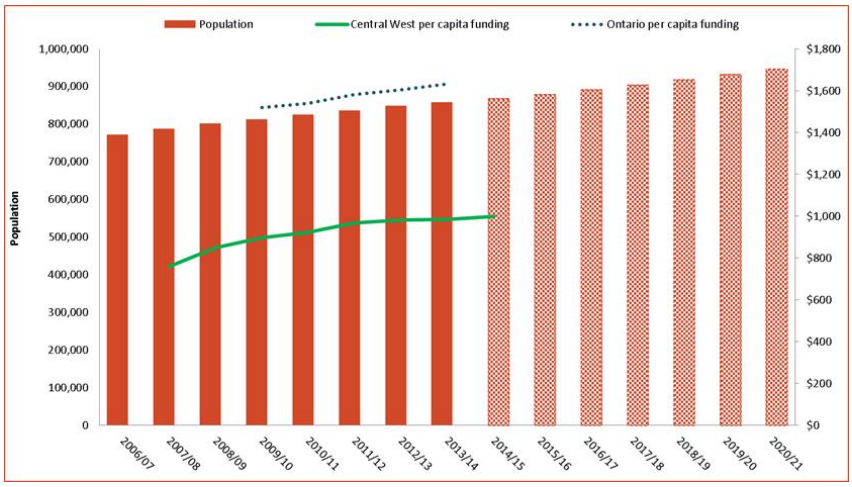
Many chronic conditions can be prevented or their onset delayed. Smoking, misuse of alcohol, excess weight, poor diet and physical inactivity are well established modifiable risk factors for many chronic conditions. The Central West LHIN has the lowest percentage of smokers (12%) and the second lowest proportion of heavy drinkers (12%) in the province. Conversely, rates for obesity (56%) and physical inactivity (54%) are higher than provincial rates.

In 2015/16, residents in the Central West LHIN made 285,888 visits to emergency departments (EDs) in Ontario, an increase of 15% over 2010/11. Most of these visits (73%) were to one of the three EDs within the Central West LHIN. At the same time, there were 256,437 ED visits to hospitals in the Central West LHIN, an increase of 18% since 2010/11. With 12% more visits annually than the next busiest site, Brampton Civic Hospital is home to the busiest emergency

department in Canada. Hospitals in the Central West LHIN had the lowest rate of visits best treated in alternative primary care settings (a 30% reduction since 2010/11), meaning that the very high number of ED visits are appropriate. ED length of stay for patients discharged home from EDs in the Central West LHIN consistently meets provincial targets. However, length of stay for patients requiring admission to an inpatient bed is substantially higher than target, suggesting a need for greater inpatient capacity.

Health Care Resources and Their Use

Over the past five years a 21% increase in base funding, totalling $150 million (from $722 million in 2009/10 to $871 million in 2014/15), has resulted in improved access to a variety of health care programs and services in the Central West LHIN.



Through a budget of $871 million, provided by the Ministry of Health and Long-Term Care (MOHLTC), the Central West LHIN funds health service providers (HSPs) and community partners in the regions of Brampton, Caledon, Dufferin County, Malton, north Etobicoke and west Woodbridge.

- 2 hospital corporations across three sites… attending over 70,000 hospital admissions and 256,400 emergency department visits/year
- 1 Community Care Access Centre (CCAC)… serving over 32,500 clients/year
- 23 Long-Term Care Homes (LTC)… providing an estimated 750,000 resident days/year
- 2 Community Health Centers (CHC) across 5 locations… delivering over 25,000 primary care visits/year
- 15 Community Support Service (CSS) agencies… offering services to over 40,000 clients/year
- 8 mental health and addictions organizations… providing over 20,000 interactions to local LHIN residents /yr.

Service Accountability Agreements	Funded	Base Funding*	% of LHIN Funding
Acute Care Hospitals	2	$ 523,350,000	60.1%
Community Care Access Centres	1	$ 115,052,000	13.2%
Community Health Centres	2	$ 12,184,000	1.4%
Community Support Services	15	$24,927,000	2.9%
Long-Term Care Homes	23	$157,686,000	18.1%
Mental Health and Addictions Services	8	$ 38,175,000	4.4%

*Based on Interim 15-16 Schedule 4.

In 2014/15, guided by recommendations contained in Dr. Samir Sinha's *Living Longer, Living Well* report, the LHIN undertook a comprehensive, long-term community capacity study of services for seniors. The community health services capacity plan identifies current service gaps, challenges within the system, and opportunities for directing investments to better meet the needs of a growing and aging population. Guided by the study's recommendations, the LHIN will continue to assess and analyze service needs and resource capacity.

In 2013/14, there were 2,500 admissions to adult designated mental health units in hospitals within the Central West LHIN. Patients discharged from these beds experienced an average length of stay of 11 days, as compared to 28 days for Ontario. Residents of the Central West LHIN had lower rates of active cases, admissions, discharges and lengths of stay compared with the province.

In 2013/14 and 2014/15, support within housing and case management had the longest median wait times among community mental health services provided in Central West LHIN. The median wait times for Central West case management, counselling and treatment, diversion and court support, early psychosis intervention, and support within housing were greater than provincial values.

Hospitals in the Central West LHIN had the shortest average provincial acute and total length of stay results in 2013/14. In 2014/15, average length of stay for alternate level of care (ALC) was 12 days - tied for shortest in the province - and hospitals in the Central West LHIN had the lowest ALC rate (inpatient capacity lost to ALC) in the province. The Central West CCAC consistently performed well in meeting 5-day guarantees for personal support and nursing services, and has among the lowest wait times for services in the community. These measures suggest hospital and community resources in the Central West LHIN are being managed efficiently.

In 2013/14, the Central West LHIN had the lowest rates for home care and nursing visits in the province, but utilization of home care services has increased over the past three years. The number of home care clients in the Central West LHIN has increased by 15%, the active client caseload has increased by 10%, visits have increased by 15%, and home care hours have increased by 51%. As the need for these services continues to grow, the LHIN must continue to invest in capacity of home care services that will be required to meet future demand.

New methods of health care funding continue to be used across the province. These funding models consider growth, population rates and needs across the LHIN, ensuring funding is directed to areas where care is needed most. The Central West LHIN will continue to work with the MOHLTC to implement health care funding reforms that allocate provincial resources in an equitable manner, recognize the growth and needs of the LHIN population, and improve capacity to deliver services for local residents.

Local Opportunities, Risks, and Drivers of System Change

Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario

Over the past decade notable gains have been made to Ontario's health care system including improved access to primary care, additional care for people at home, reduced hospital wait times, investments in health promotion programs, and steps taken to make the system more transparent and more accountable. But there are still gaps in care.

Many of these challenges arise from the disparate way different health services are planned and managed. While local hospital, long-term care, community services and mental health and addiction services are all planned by the province's 14 LHINs, primary care, home and community care services and public health services are planned by separate entities in different ways. Because of these different structures, LHINs are not able to align and integrate all health services within their communities.

On December 17, 2015, the MOHLTC released the discussion paper Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario. A driver for system change, the document outlines a series of four proposals related to the next phase of the MOHLTC's plan to put patients first, further integrating the system to address structural issues that create inequities. They include:

Effective Integration of Services and Greater Equity	• **Make LHINs responsible for all health service planning and performance.** • **Identify sub-LHIN regions as the focal point for integrated service planning and delivery.**
Timely Access to, and Better Integration of, Primary Care	• **LHINs would take on responsibility for primary care planning and performance improvement, in partnership with local clinical leaders.**
More Consistent and Accessible Home & Community Care	• **Direct responsibility for service management and delivery would be transferred from CCACs to the LHINs.**
Stronger Links to Population & Public Health	• **Linkages between LHINs and Public Health units would be formalized.**

The four proposals contained in the discussion document are fully aligned with the strategic directions outlined in the Central West LHIN's IHSP 2016-2019.

Notably, *Effective Integration of Services and Greater Equity, Timely Access to, and Better Integration of Primary Care, and More Consistent and Accessible Home and Community Care* align perfectly with the LHIN's Strategic Direction to *Build Integrated Networks of Care*. The discussion document proposes that LHINs would be responsible for working with providers across the care continuum to improve access to high-quality and consistent care, and to make the system easier to navigate. Through such strategies as Health Links and Home and Community Care Renewal, the LHIN will work to better integrate existing resources into strong networks of care, investing in those

areas that require additional capacity to meet the needs of a growing, aging, and ethnically diverse population. The LHIN also remains committed to the planning, development and delivery of innovative and creative health care programs and services that meet the current and future needs of LHIN communities.

The discussion document also proposes to formalize *Stronger Links to Population and Public Health* which aligns with IHSP 2016-2019's Strategic Direction to *Demonstrate System Leadership* – specifically, as it relates to population health. LHINs will integrate local population and public health planning with other health services. By demonstrating system leadership with respect to public health, IHSP 2016-2019 acknowledges the Central West LHIN needs to understand population health in order to target resources accordingly, improve outcomes, and promote sustainability within a broader health equity framework.

Community Capacity Plan

Acknowledging rapid population growth within the Central West LHIN, specifically as it relates to a projected increase in the seniors population, the Central West LHIN responded to the call to create a system capacity plan (detailed within *Patients First*: A Roadmap to Strengthen Home and Community Care) by completing a community capacity plan of services for seniors. The local seniors' strategy, which is being derived from the recommendations of the capacity study and will encompass the various provincial and local renewal strategies, will serve as a driver of local health system change moving forward.

Build Integrated Networks of Care

Health Links and Primary Care

IHSP Initiative Description | Primary care renewal is focused on improving and coordinating care for the entire population, with Health Links initially focused on driving positive outcomes specifically related to the care of people with complex conditions.

Medically complex and frail individuals typically have multiple diagnoses and complex medication regimens. Their circumstances significantly impair their ability to perform one or more activities in their daily living, which often makes them reliant on caregivers and/or community-based services for support. These individuals are often seniors, and are generally high users of the system who require frequent, consistent, collaborative and high-quality care. It follows that for this patient population, family and caregivers often suffer "burnout" that requires respite care as a result.

Efforts to meet the needs of these residents will be closely connected to the ongoing development of home and community care renewal initiatives, and to the five Health Links established across the Central West LHIN's entire geographic area including Bolton-Caledon, Bramalea and area, Brampton and area, Dufferin and area, and North Etobicoke-Malton-West Woodbridge.

The Central West Local Health Integration Network (LHIN) will work with primary care providers (aligned with sub-LHIN Health Link geographies) to ensure they are an integrated part of the local health care system. In keeping with provincial policy initiatives, and mindful of the diverse needs of LHIN communities, the LHIN will collaborate with the province and local primary care providers in an effort to renew primary care provision and ensure adequate primary care resource planning.

Ensuring the availability of adequate health human resources is critical for population health and health equity in the Central West LHIN.

Current Status | The Central West LHIN continues to work with Family Health Teams (FHTs), Community Health Centres (CHCs), and primary care practitioners practicing in other models of organized care, to ensure residents have timely access to multi-disciplinary primary care, provided in appropriate settings as close to home as possible. Of note, the LHIN is working with providers to develop systems and processes that will reduce or delay avoidable visits to emergency departments (EDs), admission to hospital inpatient units, and applications to Long-Term Care.

Approximately 560 family physicians provide care throughout the Central West LHIN (*Ontario Physician Health Data Resource Centre, 2013). Residents have access to six FHTs, two CHCs, 33 Family Health Groups (FHGs), 13 Family Health Organizations (FHOs) and over 180 individual fee-for-service practitioners. Attachment to a primary care physician is high, with 95% of residents of the Central West LHIN reporting they had a regular family doctor in 2013/14 (*Health Care Experience Survey, June 2014). While most residents report having a family doctor, only 54% of residents reported that they could see their primary care provider on the same or next day when sick.

Residents do not appear to be turning to local EDs for conditions that should be manageable within the community. Despite Brampton Civic Hospital (BCH) having the busiest ED in Ontario (137,818 visits in 2015/16, as compared to 123,132 at Humber River - the next busiest ED in Ontario), the three EDs in the Central West LHIN have lower proportions of low acuity visits compared to the province as a whole (Canadian Triage and Acuity Scale (CTAS) IV/V: 17% vs. 32%) and the lowest rate of ED visits among the 14 LHINs for conditions such as conjunctivitis, cystitis, otitis media and upper respiratory infections, that could be treated in primary care settings (1.1 per 1,000 population aged 1-74 years in 2013/14).

Led by the Central West Physician Primary Care Lead, the Central West LHIN continues to support the Central West Primary Care Network in its efforts to develop diverse partnerships and strategies that engage local primary care practitioners, particularly in initiatives such as Health Links. In light of *Patients First*: A Proposal to Strengthen Patient-Centred Health Care, and as the Central West LHIN continues to focus efforts on the ongoing development of Health Links as sub-LHIN planning areas, it will be increasingly important to engage local clinical leadership to co-design this work and engage their colleagues.

Alignment with Government Priorities | Ontario's *Patients First:* Action Plan for Health Care identifies timely access to primary care and improved transitions among providers as key components toward ensuring the needs of residents and patients remain at the centre of care. The provinces' *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario identifies opportunities for greater access to primary care and seamless links between primary care and other services. Through the collaborative work of Health Links, FHTs, CHCs, the Central West CCAC, and the Central West Primary Care Network, patients will receive faster care, spend less time waiting for service and will be supported by a team of providers across the health care system.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Identify and enroll all Health Link patients in the LHIN, starting with medically complex and frail typically affected by presence of multiple chronic diseases.	In Progress	30		30		30
Continue to support the implementation of the Health Links Care Coordination Tool in proof of concept and spread it to other Health Links.	In Progress	20		30		30
Develop a new population-based case management model.	In Progress	40		30		20
Confirm a governance and sustainability model for Health Links.	In Progress	50		30		10
Establish a Central West LHIN framework to advance local primary care renewal, flexible to align with other provincial initiatives such as home and community care renewal.	In Progress	50		30	Ongoing	
Identify sub-LHIN clinical leadership to develop and support local primary care renewal strategies as well as the scale of Health Links.	Not Yet Started	60		40	Ongoing	
Engage in primary care physician workforce planning within the Central West LHIN in collaboration with HealthForce Ontario and other provincial partners	In Progress	30		30	Ongoing	
Maximize the use of virtual care technologies including Telehomecare and other developing technologies.	In Progress	30		30	Ongoing	

Expected Impacts of Key Action Items (How we will measure success?)

More residents will have access to after-hours care and same-day or next-day appointments and fewer individuals will require care in hospitals for conditions that are better managed in primary care settings.

- Increase the proportion of residents who report access to same or next-day appointments to 75%.
- Spread and scale Health Links across all five Health Links and reach a target of 10,000 coordinated care plans.
- Reduce the proportion of identified Health Links patients accessing emergency department and inpatient acute care services by 25%.
- Maintain current performance on avoidable emergency department visits for conjunctivitis, cystitis, otitis media and upper respiratory infections (< 1.5 visits per 1,000 population aged 1-74 years).
- Increase the proportion of client enrollment into the Telehomecare program by 10% with a yearly target of 550 clients for the fiscal year 2016/17.
- Improve the rate of readmissions within 30-days of discharge for congestive heart failure (CHF) diagnoses to within 10% of the expected rate.
- Improve the rate of readmissions within 30-days of discharge for chronic obstructive pulmonary disease (COPD) diagnoses to within 10% of the expected rate.
- Maintain a rate of readmissions within 30-days of discharge for diabetes diagnoses within 10% of the expected rate.

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
Year-over-year population growth will increase pressure on the availability of and access to local family physicians for residents within the Central West LHIN.	▪ Continue to use and monitor referral patterns to primary care through Health Care Connect. ▪ Monitor physician supply, recruitment and model adoption through the LHIN's Health Force Ontario Community Partnership Coordinator. ▪ Monitor referral patterns to Health Links for barriers to access and growth in demand. ▪ Collaborate with the Central West LHIN Chronic Disease Management team to develop common referral and disease pathways.
Access to and communication of relevant patient information across Health Service Providers impedes timely access to care.	▪ Continue to adopt and support the use of eHealth and telemedicine infrastructures that improve the availability, transferability and coordination of client-based care.
Varying levels of physician support for Central West LHIN initiatives.	▪ The Central West LHIN will continue to work with the Ministry of Health and Long-Term Care (MOHLTC) and member based organizations such as the Ontario Medical Association (OMA) and Ontario College of Family Physicians (OCFP), physician leadership, the Primary Care Lead and Central West Primary Care Network and Central West LHIN Core Action Groups (CAGs) to support physician championship of programs and services. ▪ The Central West LHIN will implement a managed implementation plan for renewal based on readiness of primary care leadership and remaining committed to physician collaboration and co-designed outcomes.

[1]Per MOHLTC guidelines, the status of work (Not Yet Started, In Progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years. Percentages may not equal 100% due to work completed in previous fiscal calendar years, or work that is expected to carry forward beyond fiscal year 2018/19.

Key Enablers | The Central West LHIN has a strong history of primary care collaboration and initiatives linked to improving primary care. Based on the *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario discussion paper, the LHIN will continue to work with the Central West LHIN Primary Care Network as well as local primary care practitioners in the sub-LHIN areas to transform primary and home and community care to ensure improved access and integration of health care services.

Success factors will include accessing a strong network of primary care leaders throughout the LHIN in collaboration with the Central West LHIN Primary Care Network, and the harnessing of LHIN CAGs – notably those linked to chronic disease prevention and management (CDPM), and mental health and addictions services - that can provide critical knowledge and advice on renewal.

A key enabler of Health Links and primary care renewal will be home and community care renewal. Ensuring complex and frail patients have timely access to home and community care services will be an important component of integrated networks of care.

Providing care to complex and frail patients involves numerous and varied care providers. Accordingly, having access to consistent, accurate, and timely patient information - in one place - is a critical success factor for Health Links. A more robust uptake of telemedicine by primary care providers and consultant physicians throughout the Central West LHIN will ensure care is available closer to home in a timelier manner. Emerging desktop-based connection technology "OTN Connect" (Ontario Telemedicine Network) should be explored as a means to support community-based care practitioners. Also, ensuring that the Care Coordination Tool is available to all care providers throughout the LHIN is essential to avoid the need for a patient and/or care giver to repeat complex history multiple times.

Home and Community Care Renewal

IHSP Initiative Description | Medically complex and frail individuals typically have multiple diagnoses and complex medication regimens. Their circumstances significantly impair their ability to perform one or more activities in their daily living, which often makes them reliant on caregivers and/or community-based services for support. These individuals are often seniors, and are generally high users of the system who require frequent, consistent, collaborative and high-quality care. It follows that for this patient population, family and caregivers often suffer "burnout" that requires respite care as a result.

With an aging population, the Ontario health system's efforts are shifting from acute or hospital-based care to community-based services. Home and community care renewal aims to keep seniors, particularly the medically complex and frail, safe and healthy and in their homes longer. This shift means having physicians and other health care providers and their patients work together to provide care in the home and community. Providers and patients alike have raised concerns about how much home and community care vary across the LHIN in terms of the types and levels of service provided.

Current Status | The Central West LHIN funds 15 Community Support Service (CSS) agencies who collectively serve over 40,000 clients per year. Meanwhile, the Central West CCAC serves over 32,000 clients per year.

In 2013/14, the Central West LHIN had the lowest rates for home care and nursing visits in the province, but utilization of home care services has increased over the past three years due in part to increased financial investment into the home care sector in the Central West LHIN. The number of home care clients in the Central West LHIN has increased by 15%, the active client caseload has increased by 10%, visits have increased by 15%, and home care hours have increased by 51%. As the need for these services continues to grow, the LHIN must consider the capacity of home care services that will be required to meet future demand.

Assisted living programs are an identified best practice in seniors care. The Central West LHIN increased funding to these programs threefold over an eighteen month period, adding 205 assisted living spaces in Shelburne, Orangeville, Brampton, Etobicoke and Woodbridge, and bringing the total number of funded places to 629.

The Alzheimer Societies of Dufferin County and Peel received funds to expand joint "First Link" programs which support individuals and their families living with dementia.

New base funding was designated to expand adult day service hours, respite programs, caregiver support programs, and Tele-Check programs.

At the Peel Manor adult day program, community funding was used to extend the hours of operation to accommodate an additional 10 seniors per day. There are now nine adult day programs in the Central West LHIN, with a capacity to serve 248 seniors.

The LHIN committed multi-year Assess and Restore investments to reinstate the Central West CCAC's home independence program (HIP) which provides targeted rehabilitation services to frail elderly in their homes.

In support of enhanced access to physiotherapy services, the LHIN provided the Central West CCAC with a base funding allocation of $1.3 million to coordinate expanded home physiotherapy services for 2,036 additional physiotherapy clients, implementing 149 exercise and falls prevention classes in 36 locations throughout the LHIN.

The MOHLTC discussion document on home and community care, *Patients First*: A Roadmap to Strengthen Home and Community Care, will be used to assist the MOHLTC in framing consultations with clients, caregivers, and providers with the objective of developing a statement of values for home and community care, a "Levels of Care Framework", and a comprehensive capacity plan by the end of 2016. These deliverables will be used to guide home and community care renewal in the Central West LHIN.

Alignment with Government Priorities | In 2015, the MOHLTC endorsed *Bringing Care Home:* Report of the Expert Group on Home & Community Care, marking a significant milestone in shaping the direction of home care in Ontario. *Bringing Care Home* was followed by *Patients First*: A Roadmap to Strengthen Home and Community Care, which outlines the MOHLTC's 10 step process for strengthening home and community care. The Central West LHIN will take a local leadership role in working with the MOHLTC as it implements recommendations and develops policies that arise from *Bringing Care Home*. In addition, the LHIN will align its work with the proposed changes outlined in *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario to ensure more consistent and accessible home and community care.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Implement local home and community care renewal in the Central West LHIN in keeping with the provincial strategy.	In Progress	40		60	Ongoing	
Establish and locally implement the new standardized levels of care and self-directed care models, based on the MOHLTC-led home and community care renewal framework.	Not Yet Started	50		50	Completed	
Expand home and community care services to meet the needs of individuals identified in the capacity plan.	In Progress	20		20		20

Expected Impacts of Key Action Items (How we will measure success?)
▪ Meet provincial target for percentage of home care clients with complex needs who received their personal support visit within 5 days of the date they were authorized for personal support services. ▪ Meet provincial target for percentage of home care clients with complex needs who received their nursing visit within 5 days of the date they were authorized for nursing services. ▪ Meet provincial target for 90th percentile wait time for CCAC In-Home Services – Application from Community setting to first CCAC services (excluding case management). ▪ Minimize wait times for assisted living and adult day programs. ▪ Decrease the proportion of patients who are designated Alternative Level of Care (ALC) to community. ▪ Decrease the 90th percentile wait time for patients who are designated ALC to community.

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
Continued growth in demand for home and community care while MOHLTC planning continues.	▪ Monitor growth in demand and strategically enhance programs where warranted.
Increase in ALC to community rates if additional capacity in home and community is not available.	▪ Monitor ALC rates in hospitals and consider alternative discharge destinations.
Increase in wait times for home care services.	▪ Monitor home care wait times and explore alternatives.
Transportation availability. Reliable and timely transportation services are needed to support vulnerable people who wish to continue living independently in their own homes.	▪ Transportation service needs will be integrated into associated care plans for those requiring home and community care services.
Increased numbers of people with higher acuity needs being maintained in the community will lead to increased caregiver burnout.	▪ Expansion of planned and emergency respite options as well as caregiver education and supports.

[1]Per MOHLTC guidelines, the status of work (Not Yet Started, In Progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years. Percentages may not equal 100% due to work completed in previous fiscal calendar years, or work that is expected to carry forward beyond fiscal year 2018/19.

Key Enablers | The LHIN will continue to build on strong partnerships with community-based providers to improve utilization of community-based services. Over the next year local planning and transition work will be led by the LHIN to ensure the establishment of the new model of home and community care, in keeping with MOHLTC directions.

Strong linkages with Health Links will ensure eligible patients are directed towards programs that will support them in their homes and avoid deconditioning. The LHIN's Services for Seniors CAG will play an important role in monitoring performance and exploring possibilities.

Care for caregivers is essential to effective home and community care renewal. Programs that support emergency and planned respite care will form an important part of the care community.

Transportation is also a key enabler toward effective home and community care renewal. Participation in community programming is often feasible only if transportation is available.

Advances in Telemedicine technology allow for greater connectivity with high-quality, patient-centred care. OTN Connect technology should be leveraged to support community-based care practitioners.

Home and community care is delivered by multiple care providers in multiple settings. Accordingly, having access to consistent, accurate, and timely patient information - in one place – is essential to prevent a patient and/or care giver from having to repeat a complex history multiple times. Use of the Rapid Electronic Access to Clinical Health Information (REACH) and Integrated Assessment Record (IAR) tools by care providers will avoid this.

Mental Health and Addictions Services

IHSP Initiative Description | Aligning with years 4-10 of *Open Minds, Healthy Minds*: Ontario's Comprehensive Mental Health and Addictions Strategy, the Central West LHIN is continuing its work with community and hospital partners to establish the right continuum of adult, community-based services that are easily accessible for all residents of the Central West LHIN, regardless of where they look or whom they ask for help. An appropriate mix of culturally appropriate, short and long-term services will integrate a social determinants of health approach, including social and family supports, and housing.

Current Status | The Central West LHIN funds eight Mental Health and Addictions organizations that collectively delivered services to over 20,000 individuals in fiscal year 2014/15. Services range in function, intensity and duration and include case management, crisis response, counselling and treatment, early intervention, support within housing, residential withdrawal management, diversion and court support, social rehabilitation/ recreation, health promotion, and employment support.

Emerging from a series of discussions among HSPs and the LHIN that took place two years ago, providers are being guided by a five-year vision for Mental Health and Addictions services - "high quality and seamless services that are easily accessed, efficient, available in a timely way, and meet the changing needs of people over their lifetime". The LHIN and HSPs discussed existing service capacity, strengths and challenges within the system, and determined priorities for program investments in 2014/15 and 2015/16.

An investment of $2.0 million in 2014/15 and $1.9 million in 2015/16 has resulted in:

- A reduction of the existing combined wait list for long-term case management and early intervention.
- Integration of addiction consultation services for residents working with Health Links to develop a single, coordinated care plan.
- Enhancement of crisis services whereby clients and their families engage more meaningfully with crisis workers, and involvement of specially trained police officers who, teamed with a regulated health professional, intervene more appropriately.
- Adoption of a person-centered and family-involved crisis planning approach consistent with local child and youth services' practice that defers to clients to decide more practical strategies for self-managing a crisis, increasing the likelihood that the crisis plan will be followed – planned implementation is underway.
- Enhancement of family support and expansion of social rehabilitation/recreation, as a systemic way to support client access to and movement between services with varying levels of intensity as needed.
- Augmentation of front-line practitioners for short-term case management and brief therapy to respond more immediately to the presenting issue and to assess more readily the need for longer term support.
- Efficient use of known housing stock to provide support within housing to 16 additional individuals and a planned approach for another 84 people, reducing the wait list by 25%.

- Capability for mental health and addictions staff to provide coordinated care in the ED, enabled through access to relevant, electronic clinical records (with client consent) at William Osler Health System (Osler) and the Central West CCAC.

Over the last three years, attention was focused on development of a System Access Model (SAM) for Mental Health and Addictions services, ensuring alignment to similar initiatives taking place in surrounding LHINs. There is full support to establish coordinated access that provides comprehensive information about support and treatment options based on the level of need, and that facilitates service transitions or interim support while waiting. The SAM was endorsed through consultations with persons with lived experience (consumers), children's mental health, development services, social services, family services, as well as within mental health and addictions sectors. Engagement is ongoing.

School boards, settlement, and psychiatry have been invited to provide feedback. Scaled, phased implementation is planned for April 2016, with one-time investments having helped to build the foundational operating aspects of the model i.e., business processes, clinical screening and assessment tools, service inventory, and pathways. Concurrent evolution of Health Links and coordinated care planning and now with the discussion paper - *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario – has led to discussions of expanding access to care to a more integrated, holistic model across a broader array of services through use of information technologies.

Alignment with Government Priorities | Improving Mental Health and Addictions services throughout the lifespan is one step toward ensuring the needs of all residents remain at the centre of their local health care system. Accordingly, the initiatives and outcomes the Central West LHIN is pursuing are aligned to Ontario's *Patients First:* Action Plan for Health Care , *Open Minds, Healthy Minds*: Ontario's Comprehensive Mental Health and Addictions Strategy, and *Moving on Mental Health:* A system that makes sense for children and youth.

Through early identification and intervention and enhanced community-based services, the LHIN is working to ensure that residents with mental health and addictions concerns receive timely access to the most appropriate services as close to home as possible.

Phase 2 of *Open Minds, Healthy Minds*: Ontario's Comprehensive Mental Health and Addictions Strategy was released in November 2014. Local improvements fully aligned with two of the provincial objectives including "Providing the Right Care, at the Right Time, in the Right Place" and "Expanding Housing, Employment Supports and Diversion and Transitions from the Justice System". More specifically, investments in community-based programs facilitated fulfilment of these objectives. Specifically, the LHIN was already developing integrated service coordination between Health Links and Ministry of Children and Youth Services Lead Agencies, and increasing supportive housing within a stable housing environment for people with mental illness and addictions who are homeless or at risk of homelessness. Through crisis services enhancements, there would be positive impact on contact with the justice system e.g. fewer avoidable contacts.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Expand community based mental health and addiction services based on capacity planning work.	Not Yet Started	60		20		20
Execute the implementation plan for the SAM – a one-stop, electronically enabled referral system so that there is "no wrong door".	Not Yet Started	25		50		25

Identify and enroll mental health and addictions clients that would benefit from Health Links.	Not Yet Started	50		25		25
Complete establishment of 100 housing units and related support services for individuals who are homeless or at risk of homelessness and continue to develop supportive housing options.	In Progress	70		10	Completed	
Partner with other funders, system planners, and providers to plan and integrate mental health and addiction services at locations designed as community service hubs.	In Progress	80	Ongoing			

Expected Impacts of Key Action Items (How we will measure success?)

- Capacity planning document is complete and serves as an input to determining investment priorities.
- Proportion of the SAM implementation plan is complete and providers are involved against targets for the year.
- SAM data demonstrates that Health Links enrollment is initiated for at least 25% of clients seeking long-term service.
- The Ontario Perception of Care (OPOC) tool is used to assess client satisfaction with the SAM.
- 100 clients are housed and provided support, and sustain housing for longer than previous experience (baseline).
- Supportive housing options are identified and documented per LHIN and municipal service managers' engagement.
- Adherence to documented, cross-sectoral plan for locating select mental health and addiction services at existing community hubs not later than fiscal year 17/18.

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
Existing structures and jurisdictional issues and boundaries may hinder the change management required to meet specific population and service location needs.	▪ The Central West LHIN will facilitate, participate in, and monitor discussions amongst local agencies and providers of children and adult services, social and human services, to share expertise and align structures, priorities and funding that support optimizing community hubs. ▪ Continued engagement with municipal housing service managers.
Program implications and associated costs with implementing an access model for mental health and addictions across the Central West LHIN's geography may be prohibitive to justify executing preferred care models.	▪ The Central West LHIN will continue to monitor and learn from the costs and considerations incurred in other LHINs undergoing similar processes. ▪ The implementation approach will be scalable in scope and cost.
Client readiness/willingness for treatment and provider capacity to respond on a timely basis may preclude successful coordinated care planning within Health Links.	▪ HSPs in the Central West LHIN understand the nature of addictions, help-seeking behavior, and stigma. ▪ Commitment to tests of change to continually improve business processes for the access model.

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Key Enablers | The Central West LHIN is committed to increasing the capacity of community-based Mental Health and Addictions services strategically, sustaining this commitment to hospital and community-based HSPs and youth serving agencies. In addition to ongoing collaboration with HSPs, electronic enablers including integrated client record, business management, and performance measurement systems are also required. Effective change management and realistic implementation strategies are keys to success.

The Central West LHIN will continue to align funding with *Open Minds, Healthy Minds*, and to work with regional staff across provincial ministries and municipalities to implement system transformation that improves mental health and well-being for residents within the Central West LHIN.

Palliative Care and End-of-Life Care

IHSP Initiative Description | The delivery of outstanding palliative care is essential for individuals and families throughout the diverse population of the Central West LHIN. The Central West LHIN wants to ensure residents die in a place of their choosing. Accordingly, over the next three years, the Central West LHIN intends to ensure:

- Capacity is enhanced for palliative care in the home and community.
- Diverse palliative care needs of the community are met.
- Public and health care providers understand options available for palliative and end-of-life care.
- Virtual technology is used as a value-add means to bring care closer to home.

The Central West Palliative Care Network (CWPCN) will support these objectives through six priorities that encompass specific action items:

- Broad Access and Increase Timeliness of Access
- Strengthen Caregiver Supports
- Strengthen Service Capacity & Human Capital in all Care Settings
- Improve Integration & Continuity Across Care Settings
- Strengthen Accountability & Introduce Mechanisms for Shared Accountability
- Build Public Awareness.

Current Status | Made up of all palliative care providers who care for residents throughout the Central West LHIN, the CWPCN has been guiding the development of palliative care services in the Central West LHIN since 2009. These services are delivered in local hospitals, private homes, long-term care (LTC) homes, and in one residential and one community hospice. One adjacent residential hospice and two community hospices also provide care to residents of the Central West LHIN.

In 2014/15, the CWPCN applied the provincial *Declaration Document* of 2011 to further develop a local palliative care system. Also in 2014/15, as a founding partner in the development of a joint palliative and end-of-life care "Pledge", the Central West LHIN took a leadership role in advancing the palliative and end-of-life conversation.

Inspired by a quotation taken from the Canadian Hospice Palliative Care Association's (CHPCA) Living Lessons® report, the Pledge reflects a commitment to coordinating care in such a way as to support HSPs across the Central West LHIN to do much more collectively than they can as separate organizations. In this fashion, the whole will be stronger than the sum of its parts.

In 2015, the MOHLTC announced a major change in the structure of palliative care networks. A new Ontario Palliative Care Network (OPCN) has been created, along with a provincial secretariat that will be responsible for providing provincial oversight of 14 LHIN palliative care programs. A new reporting structure was introduced which calls for the regional palliative care programs to report to the respective LHIN CEOs, and the local Cancer Care Ontario (CCO), Vice President.

Alignment with Government Priorities | Since 2011, the development of palliative care programs within Ontario's 14 LHINs has been guided by the *Declaration Document*, which was produced by a panel consisting of MOHLTC, LHIN, and health service representatives.

In 2014, the strengthening of palliative and end-of-life care was noted within the Premier's Mandate Letters to the Minister of Health and Long-Term Care and Parliamentary Assistant John Fraser who was given specific responsibility for a provincial palliative care strategy.

Released in 2015, Ontario's *Patients First*: A Roadmap to Strengthen Home and Community Care calls for greater choice in palliative and end-of-life care as one of its 10 steps to improving home and community care. The MOHLTC also calls for expanded access and equity, and new supports for caregivers. The LHIN will leverage the opportunities outlined in *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario to plan for better palliative and end-of-life care by using a sub-LHIN population based approach.

Redevelopment of the CWPCN will incorporate the January 2016 Discussion Guide entitled "Establishing Common Elements for Regional Palliative Care Programs". This document outlines the structure and accountability, operating principles, and anticipated outcomes of a regional palliative care program.

In January 2016, the CWPCN participated in a province wide, MOHLTC-led survey of residential hospice capacity. The need for additional residential hospice beds in the Central West LHIN was identified. The CWPCN will facilitate ongoing discussions with the MOHLTC and palliative care HSPs.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Develop an education strategy incorporating education for the public, providers and clinicians that includes the spreading of the "Pledge".	In progress	75	Completed			
Develop a regional strategic plan and a unified work plan in alignment with provincial network directions.	In Progress	50		25		25
Integrate palliative care into Health Link care plans.	In Progress	50		30	Ongoing	
Increase access to LEAP (Learning Essential Approaches to Palliative and end-of-life care) courses for health care providers.	In Progress	33	Ongoing			

Expected Impacts of Key Action Items (How we will measure success?)
▪ Increase awareness of LEAP programs. ▪ Decrease the time from admission to acceptance in LEAP programs. ▪ Increase the number of health service providers trained in LEAP. ▪ 100% of 2015/16 palliative care patients have a Health Link care plan. ▪ Increase the proportion of people who die in their place of choice. ▪ Establish and maintain an appropriate average length of stay in hospice beds. ▪ Decrease the proportion of people who die waiting for a hospice bed.

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
Hospices rely on fundraising for all capital and considerable amounts of annual operations. Reductions in funds raised can lead to reductions in programming and delays in capital projects.	▪ Provide LHIN funding where allowable.
Primary care physicians are reluctant to declare patients as palliative, resulting in delays in accessing programs that would be of benefit.	▪ Continue to explore all opportunities to educate primary care physicians on palliative care, including the use of the "surprise question".
Many people have little understanding of palliative care and are ill prepared for end of life discussions.	▪ Continue to bring the concept of advanced care planning to the mainstream. ▪ Family physicians should promote advanced care planning in their practice.

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Key Enablers | A significant number of Health Links patients would qualify as being palliative, and it is important that Health Link physicians and care coordinators be aware of the full expanse of palliative care options available locally. All Health Link care coordinators should receive education regarding early identification of patients who can benefit from palliative care and services that are available.

Hospice programs are delivered by grass roots organizations that require significant volunteer hours for service delivery. Additionally, hospices rely on fundraising for both capital and operational

needs. The availability of trained, motivated volunteers and fundraisers is key to the success of hospice programs.

Advances in Telemedicine technology allows for greater connectivity with palliative care experts. OTN Connect technology should be leveraged to support community-based palliative care practitioners.

Palliative care is delivered by multiple care providers in multiple settings. Accordingly, having access to consistent, accurate, and timely patient information - in one place – is essential to avoid the need for a patient and/or care giver to repeat a complex history multiple times. Use of the REACH and IAR tools by palliative care providers will avoid this, in addition to a chart in the home for patients who are in the palliative care program.

The CWPCN plays an important role in the development and evaluation of palliative care programs and services.

Caring for a palliative care patient can be exhausting for a family. Care for caregiver programs including respite programs and bereavement counselling are key enablers. Community agencies such as assisted living programs are increasingly caring for people approaching the end of their lives. Education in palliative care principles for assisted living staff will enhance their ability to provide high quality care for people in assisted living and avoid having to transition to a care facility.

Long-Term Care Renewal

IHSP Initiative Description | The province of Ontario has recently committed to helping LTC Home operators redevelop approximately 300 older homes across the province, bringing them in line with the contemporary design standards. This redevelopment will improve accommodations for seniors and other populations requiring LTC including those with dementia. The Central West LHIN will support this redevelopment initiative for the seven homes within the LHIN that are eligible for redevelopment.

The Central West LHIN is reviewing the need for designated units in LTC Homes (e.g. Behavioural Support Units), and will work with eligible homes to incorporate these units where appropriate. The LHIN is also exploring the development of seniors hubs and Program for Advanced Care for the Elderly (PACE) models of care, both of which can include LTC as part of their constellation of services. Where practical, a redeveloped home may be developed as part of a seniors hub.

Current Status | The Central West LHIN has 23 LTC Homes throughout its geographical area, seven of which 7 are eligible for redevelopment under the MOHLTC Enhanced Long Term Care Home Renewal Strategy (ELTCHRS). One additional home is ineligible for the MOHLTC program but is actively proceeding with redevelopment plans. Two homes took advantage of a previous MOHLTC redevelopment program; one renewal project is complete, and the second will complete Phase II of its project in July 2016.

Alignment with Government Priorities | Recommendations contained in Dr. Samir Sinha's *Living Longer, Living Well* report (2012, noted the redevelopment of older LTC Homes and that, as part of redevelopment, LTC Homes could become part of seniors hubs. Ontario's *Patients First:* Action Plan for Health Care identifies the redevelopment of older LTC Homes as a priority. The MOHLTC released ELTCHRS in October 2014 and has created an entire department to manage the redevelopment initiative.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Redevelop all eligible Long-Term Care homes in the Central West LHIN.	In progress	14		14		14
Develop and implement a Central West PACE-like program.	In progress	40		20		20
Incorporate innovative design into the redevelopment of LTC Homes including the potential for enhanced specialty / behavioural units and the creation of community service hubs.	In progress	14		14		14

Expected Impacts of Key Action Items (How we will measure success?)
▪ Decrease the 90th percentile wait time for a basic accommodation bed in LTC. ▪ Proportion of homes with approved redevelopment plans. ▪ Maintain the appropriate LTC home occupancy.

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
Some long term care homes may have to decant their residents to a temporary location during construction.	▪ Work with partners in long-term care to identify temporary space options.
Homes that are unable to decant their residents to other sites will have to close LTC beds during the redevelopment period.	▪ Undertake a "Beds in Abeyance" program to mitigate the loss of the beds.

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Key Enablers | Once the LHIN has reviewed a project, the redevelopment process takes place primarily between the MOHLTC and the operator. The LHIN will monitor progress on redevelopment projects, and assist in planning any mitigation strategies (e.g. decanting) that may be required.

The Central West LHIN has experience in managing beds in abeyance (BIA) funding from the first round of redevelopment.

Drive Quality and Value

Improve the Patient Experience

IHSP Initiative Description | The patient's experience of care is recognized as being integral to a high-quality, high performing, and value-driven health care system, aligned with the objectives of Ontario's *Patients First:* Action Plan for Health Care.

Residents in the Central West LHIN report positive levels of satisfaction with their local health care system. However, due to difficulties with accessing and navigating services, the ways by which information is communicated, and/or confusion over appropriate care plans, residents of the Central West LHIN often find interactions with the health care system to be confusing and/or stressful.

To better understand their needs, HSPs throughout the LHIN are increasingly asking patients about their experiences with the health care system in order to make improvements accordingly.

Current Status | The Central West LHIN Board Quality Committee is currently consulting with members of boards and senior leadership teams of service providers in the Central West LHIN on their respective initiatives in measuring and monitoring patient/client experience. Representatives from all Central West LHIN funded health service sectors are participating, sharing their initiatives and thoughts on quality and how to best implement a LHIN-wide approach that will be representative of the experience residents in the Central West LHIN describe about their encounters with the local health care system. This information, coupled with MOHLTC, Health Quality Ontario (HQO) and other jurisdictional strategies will help inform and guide this work.

Alignment with Government Priorities | Improving patient experience is integral to the MOHLTC's *Patients First:* Action Plan for Health Care. As the MOHLTC, LHIN and system partners begin to implement transformation strategies, it will be necessary to capture and monitor patient experience measures that reflect an increasing accountability for improvements that are sustainable, affordable and that put people and patients first by improving both their health care experience and their health outcomes.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Continue implementing and monitoring patient experience as a system level quality aim.	Ongoing					
Align local patient experience improvement initiatives with MOHLTC and HQO.	In Progress	75	Ongoing			
Collaborate with Central West LHIN HSPs to ensure a common and consistent component of patient experience measurement is implemented across the LHIN.	In Progress	80	Ongoing			

Expected Impacts of Key Action Items (How we will measure success?)	
▪ TBD – metric(s) will be determined once stakeholder consultation is complete. ▪ Overall satisfaction with health care in the community (Ministry-LHIN Accountability Agreement, MLAA). ▪ Metrics will reflect local system priorities and will be aligned with and/or augmented by MOHLTC and HQO initiatives.	
Risks/Barriers to Successful Intervention	
Risk	**Mitigation Strategy**
Unable to identify common patient experience measure(s) across multiple health service sectors that is representative of the Central West Health system as a whole and aligns with Ministry-LHIN Accountability Agreement (MLAA) performance reporting.	▪ Assure a combination of measures that captures common quality dimension(s) across sectors.
Misalignment of local and provincial approaches to measuring and monitoring patient experience.	▪ Consultation with MOHLTC and HQO to assure alignment or acceptable variation and avoid duplication of efforts.

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Enablers | It will be essential to identify the common measure(s) and determine that the appropriate sources of data to support the measurement and monitoring of patient experience exist and implementation of viable supporting processes occurs.

Quality and Innovation

IHSP Initiative Description

Quality | The Central West LHIN is committed to ensuring controls and accountabilities are in place that address quality in health care, patient safety, and system effectiveness. Continued collaboration with HSPs to create and sustain a culture of quality improvement across the LHIN is an essential element of the LHIN's role with respect to system oversight.

The Central West LHIN will achieve this through:

- Monitoring the implementation of the Excellent Care for All Act (ECFAA) and its implications for the LHIN.
- Advancing quality and its continuous improvement across the health care sectors.
- Supporting and implementing transparent plans and processes dedicated to drive improvement in the quality of the health care system with particular attention to cross-sector improvement /redesign.
- Implementing and monitoring measures, controls and accountabilities that address areas of quality of the system.

Innovation | When people think about transformation or innovation in health care, they tend to think about new drugs or surgical techniques. However, innovation in service delivery – how care gets delivered, who does what, where, and when – is just as important for the long-term improvement and sustainability of the local health care system.

The Central West LHIN will be developing a strategy to support innovation and identification of best practices and knowledge transfer as a component of a renewed quality framework being targeted to commence implementation in 2016/17.

Current Status | The Central West LHIN is committed to implementation of a local quality framework and agenda through collaboration with local and provincial partners that places patients first and enhances their experience with the local health system and their health outcomes. The LHIN is currently working with HQO in recruiting a clinical quality lead for the LHIN and in establishing a regional quality table that will be integral to the local quality framework and help align local and provincial quality agendas.

The Central West LHIN has incorporated in all of the accountability agreements that it holds with health service providers the requirement for them to be accredited by March 31, 2017. For the most part, progress against this requirement is on track. The LHIN also required HSPs to submit quality plans to the LHINs – both the Quality Improvement Plans (QIPs) required by legislation as well as plans from HSPs not yet required to submit formal QIPs. Plans are in development to collaborate with local health service providers to identify opportunities to align quality strategies and support for the system level quality improvement aims that the LHIN has established. With the implementation of a new three-year health system plan in 2016-17, the LHIN will determine the need to revisit, confirm existing and/or establish additional quality improvement aims to reflect priories identified in the IHSP 2016-2019.

Alignment with Government Priorities | The province's commitment to quality health services and improved health outcomes for all Ontarians was integral to the ECFAA, enacted in 2010, and in the Minister Mandate Letters related to driving a sustainable, accountable and quality health care system. Quality-focused initiatives underway or being proposed by the Central West LHIN support the provincial quality agenda.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
In partnership with HQO, appoint a Clinical Quality Lead/Chair and establish a quality table to support the development and implementation of a local quality plan and promote a cross-sector culture of quality.	In progress	80	Complete			
Continue with existing and/ or establish new system level Quality Improvement aims that align with Central West and provincial strategic priorities.	Ongoing					
Ensure all HSPs are appropriately accredited.	In progress	50	Ongoing			
Ensure that Central West HSPs are aligned to QIPs and the Central West LHIN Quality Improvement Framework.	In progress	75	Ongoing			
Collaborate with HQO to align provincial and LHIN level quality agenda.	In progress	75	Completed			
Develop a formal knowledge sharing forum for best practices across organizations and sectors.	Not Yet Started	50		50	Ongoing	

Collaborate with HQO and other LHINs and stakeholders to identify leading practices and innovations that can be shared with and adopted by Central West LHIN HSPs where applicable.	Not Yet Started	50		30		20

Expected Impacts of Key Action Items (How we will measure success?)
▪ Rate of care plan implementation within the 5 Central West LHIN Health Links. ▪ Rate of repeat emergency department visits for patients with mental health and substance abuse conditions. ▪ Percentage of HSPs that achieved accreditation by March 31, 2017. ▪ Percentage of HSPs submitting quality plans. ▪ Metrics associated with newly implemented system level quality improvement aims, if any, aligned with IHSP2016-2019 and/or provincial quality improvement goals.

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
Provincial and local stakeholders may face competing demands, duplication or inconsistencies related to quality improvement initiatives.	▪ Continued implementation of a Central West LHIN quality improvement framework, system level quality improvement aims and establishment of a local quality table will help assure stakeholder alignment.
Variation in the resource capacity of health service providers to participate and support both an organizational and common LHIN quality improvement agenda.	▪ The Central West LHIN will continue to work with its HSPs to build capacity for quality improvement, facilitate uptake of provincial training and coaching programs such as Improving and Driving Excellence Across Sectors (IDEAS), and support accreditation initiatives and Central West system level alignment of quality improvement plans.

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Key Enablers | The Central West LHIN will drive improvement in quality and safety through the continued development and implementation of an overarching framework for quality. To be successful, collaboration, alignment and coordination of provincial (HQO) and regional strategies among the Central West LHIN and local health service providers will be needed to optimize the impact of improvement efforts. Expertise, resources, sharing of best practices and acknowledgement of successes are necessary to advance a culture of continuous quality improvement.

Health System Funding Reform

IHSP Initiative Descriptor | The Central West LHIN and many local HSPs now operate in a *patient-based funding* environment known as Health System Funding Reform (HSFR). HSFR is a new way of funding hospitals and community providers based on the burden of illness and care needs in the community, where patients actually go for care, the quality of providers' care, and the efficiency of that care. It represents a fairer means of funding health care across the province that also incents the best possible care in the most efficient way possible – in other words, to drive quality and value. In this environment, the Central West LHIN intends to:

- further support the provincial HSFR strategy
- work to better align funding to need and evidence-based practice.

Current Status | The Central West LHIN continues to advance the provincial HSFR strategy through active participation in the pan-LHIN HSFR Advisory Committee and the MOHLTC's renewed HSFR governance structure and implementation of annual HSFR initiatives with local health service providers. The Central West LHIN continues to identify and monitor the health service needs of the local community and works toward the goal of putting patient's needs first while aligning funding and delivery of high quality care in an affordable and sustainable manner.

HSPs in the Central West LHIN have actively supported HSFR quality improvement and change management strategies by participating in three cohorts of the provincial IDEAS program and continue to collaborate on implementation of Quality- Based Procedures (QBPs). To date HSP leadership have established a number of QBP implementation teams that have or are currently implementing strategies for alignment with best practice and health outcomes. Planning is underway to work more closely with HQO to further align QBP and quality goals locally.

On September 2, 2015, the MOHLTC announced six innovative projects focused on the patient experience that would test innovative integrated approaches of service delivery and new integrated funding models intended to improve the delivery of quality, evidenced-based care to patients. *Hospital to Home (H2H)*: The *Central West Integrated Care Model* was one of these selected projects. H2H is a model of care that will better enable seamless patient transitions from the hospital to the community. It is a joint initiative of the Central West CCAC, Headwaters Health Care Centre (HHCC) and William Osler Health System (Osler), working with OTN.

Beginning on December 1, 2015, H2H will enrol patients from Osler's Etobicoke General Hospital (EGH) site, with implementation to follow at HHCC (January 2016) and Osler's Brampton Civic Hospital (BCH) site (February 2016). In the first year, H2H will support patients diagnosed with cellulitis and/or urinary tract infections requiring short-term nursing interventions. In years two and three, the model will be expanded to more complex care using both nursing and interdisciplinary models, including palliative care, stroke, chronic diseases, and appropriate post-surgical procedures, and redefine the interactions and experiences of these patients with the health care system. The H2H model supports a strategic shift to more community-focused, scheduled care, supporting people to receive care in their homes or in the community, helping prevent avoidable emergency department visits and hospital admissions, shortening the acute length of stay for admitted patients, providing greater continuity of care and enhancing the patient experience.

The Central West LHIN investment strategies are informed through assessment of local health needs and a prioritization analysis established through the application of a decision-making and evaluation framework with rating criteria aligned to provincial and local health service priorities and identified service delivery gaps. Targeting investment strategies in this manner helps assure that the application of available funding is undertaken in a prudent, cost effective and beneficial manner that is aimed at maximizing the impact of the investment on improvement in the health status of the local population. The LHIN will continue to encourage and provide support where applicable for health service providers to continue to participate in the provincial IDEAS program to build quality and change management capacity locally.

Alignment with Government Priorities | The Central West LHIN is committed to support the MOHLTC's continued investment in HSFR and to providing leadership for quality in the implementation of HSFR to drive quality and value.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
In support of MOHLTC continued implementation of the Health-Based Allocation Model (HBAM), make evidence-informed, patients first investment decisions that are consistent with current population growth to improve service level and satisfaction measures.	Ongoing					
Drive local implementation of appropriate volumes of Quality-Based Procedures (QBPs) in collaboration with the MOHLTC, HQO and CCO.	Ongoing					
Continue to implement and evaluate the first phase of innovative funding models such as bundled payments.	In Progress	60	Ongoing			
Continue to support HSPs with implementation of strategies to build capacity in quality improvement, leadership and change management across the Central West LHIN.	In Progress	60	Ongoing			

Expected Impacts of Key Action Items (How we will measure success?)

- H2H – for these patients, performance metrics will be recorded and reported to demonstrate fewer emergency visits and admissions, supporting people to receive care in their homes or in the community, shortening the acute length of stay for admitted patients, providing greater continuity of care and enhancing the patient experience.
- Central West LHIN provincial HSFR and wait time share allocations are more closely aligned to reflect local priorities and needs.
- 100% of investment decisions are aligned to local priorities and needs with application of Decision Making and Evaluation Framework rating criteria.
- Percent of priority 2, 3 and 4 cases completed within access target for hip replacement.
- Percent of priority 2, 3 and 4 cases completed within access target for knee replacement.
- Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery.
- Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery.

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
H2H – moving from Monday to Friday 9 to 5 programming to 24/7 service delivery will likely increase the number of patients receiving care and impact on costs.	▪ The new funding model, incorporating a "carve-out" of existing CCAC expenses for these patients, will support service costs and will be augmented by additional funding support from the three partners.
HSFR – provincial HSFR and wait-time share calculations are not more closely aligned to better meet local need.	▪ Actively participate in provincial planning and funding initiatives with appropriate needs-based allocation being a primary principle for participation.

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Key Enablers | For the H2H initiative the LHIN has worked closely with the Central West CCAC, HHCC, Osler and OTN, along with the MOHLTC to establish the model and monitor its performance through regular check-in meetings. A business case and program charter have been completed and the funding "carve-out" has been agreed to by all partners. A provincial led process is in place to evaluate the performance of these Integrated Funding Model projects after their first year.

For HSFR (HBAM and QBP) reallocations there must be a willingness and support amongst provincial stakeholders to establish a renewed allocation model that adequately takes into consideration factors in a manner that leads to better alignment of funding to local growth and needs.

Enabling Technology Integration

IHSP Initiative Description | Information technology (IT) and information management (IM) are key elements that enable the empowerment of patients, and connect their continuum of care. They eliminate the need to capture the same information from residents of the Central West LHIN multiple times, supporting patients, their caregivers, and their health service providers to share information and coordinate services quickly and efficiently as they transition from one care provider to another.

Leveraging IM/IT investments made at the local, regional, and provincial levels will drive health care transformation and enable informed system planning decisions. Solutions have been identified for implementation over the next three years that will support IHSP 2016-2019, and are identified in the *Enabling Technologies for Integration (ETI) PMO Funding Business Plan* – Central Ontario Cluster, including eConsult, eNotifications, Connecting GTA (cGTA), Hospital Report Manager (HRM), eReferral, Electronic Medical Record (EMR), Health Links Care Coordination Tool (CCT) and the Community Services IM/IT Model.

The Central West LHIN will work in partnership with OTN to implement effective and appropriate telemedicine technologies (e.g. Telehomecare and personal computer and video conferencing) to improve access to care for residents of the Central West LHIN. These OTN tools will be implemented in established clinical pathways and health care services, which will add value and ensure patients and providers have an enhanced experience through care delivery.

Current Status | In 2015/16, the Central West LHIN continued to make significant strides in planning and implementing enabling technology solutions. All hospitals in the Central west LHIN are now live using HRM. HRM electronically delivers medical record reports (e.g. discharge summary) and transcribed diagnostic imaging (excluding image) reports from hospitals directly into the patients' charts in the clinicians' EMR system. The hospitals continue to expand electronic access of their hospital reports to primary care physicians and specialists through the use of the HRM product.

The Central West LHIN continues to have the highest adoption rate of EMRs in the province for both primary care physicians and specialists. Focus for 2016/17 will shift to look at ways to enhance the use of EMRs for improved patient care.

The Integrated Assessment Record (IAR) is an electronic tool that allows client assessments to move with the client from one HSP to another. It allows participating HSPs to upload and view the assessment information from consenting clients regardless of where the original assessment was completed. Use of the IAR by HSPs in the Central West LHIN is stable at 63%. Accordingly, the LHIN will look to continue the increase of usage of the IAR by HSPs in the coming year.

The cGTA project continues to work with HSPs to provide a single point of access to patient health information. Osler is live feeding data to the cGTA data repository, and viewing patient information from the 11 early adopter hospitals and six CCACs located in the GTA. HHCC is targeted to go live, feeding and viewing patient data in cGTA, in the 2016/17 fiscal year. HHCC, along with 10 additional Central West LHIN HSPs, is included in the cGTA expansion phase. Represented are HSPs from the Primary Care, LTC Home, Mental Health and Addictions, and CSS sectors.

In 2015, to better understand IM/IT in the community sector, a survey was issued to Community Sector HSPs across the Central, Central East, Central West and Mississauga Halton LHINs. The survey collected a broad range of data that has been populated into a database tool for analysis. The collated and cleansed data has been assessed and identification of a set of IM/IT opportunities that can be specifically targeted to the community sector HSPs have been identified. Identified opportunities are currently being assessed for implementation.

The need for central intake processes, and a referral management solution to support the intake processes, has been identified by multiple providers for multiple patient care pathways across the Central West LHIN. Work will continue in 2016/17 to identify and define patient care pathways in need of a central intake solution, to support the implementation of a single referral management solution for all pathways. Examples of care pathways include Health Link referrals, mental health and additions referrals, diabetes referrals, and primary care to specialist referrals.

The Central West LHIN will continue to monitor the Provincial rollout of eNotification and eConsult projects closely with a plan to implement the solutions as soon as they are broadly available.

Alignment with Government Priorities | Information technology and information management are enablers that support - and can be woven through - all four objectives identified within Ontario's *Patients First:* Action Plan for Health Care. The action plans identified below will enable the objectives of *Patients First* and support health system collaboration through the use of information technologies.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Implement priorities identified in the Central Ontario Cluster Enabling Technologies for Integration Business Plan including:						
▪ Connecting GTA	In Progress	20		20		20
▪ HRM	In Progress	40		20		20
▪ eNotifications	In Progress	10		60		20
▪ eConsult	Not Yet	20		70		10
▪ Community Services IM/IT Model	Started					
▪ Central Intake Solution/Referral	In Progress	20		20		10
Management.	In Progress	20		20		20
Spread the SAM beyond the Mental Health and Addictions sector.	In Progress	30		60		10

Expected Impacts of Key Action Items (How we will measure success?)	
▪ Increase the number users actively using cGTA. ▪ Increase the number of hospital reports transmitted electronically from hospitals to physician EMRs. ▪ Increase the number of hospitals and physicians using the HRM platform. ▪ Increase the percentage of specialists who have implemented an EMR. ▪ Increase the number of local users actively searching and using the IAR. ▪ Reduce the time it takes for physicians and patients to connect with a care coordinator and receive requested community services. ▪ Measure the wait times for a patient to receive provider services from the time of referral to completion of service. ▪ Identify opportunities to reduce the IM/IT costs experienced by community service providers. ▪ Reduction in the number of unnecessary referrals to specialists through eConsult.	
Risks/Barriers to Successful Intervention	
Risk	**Mitigation Strategy**
HSPs have limited physical, capital and human resource capacity to implement, sustain and monitor IM/IT solutions.	▪ The LHIN will facilitate ongoing dialogue with Health Service Providers to understand their priorities and capabilities and align activities where possible. ▪ Identify a champion health lead for each IM/IT project. ▪ The LHIN will continue to build stakeholder awareness, engagement and buy in for IM/IT solutions as early as possible. ▪ Ensure that a sustainability model is created and communicated to the HSPs and to the LHIN in advance of committing to project implementation.
Uncertainty regarding government priorities for IM/IT may impact engagement and participation of health care system stakeholders and champions.	▪ Commitment to government priorities will be reinforced through stakeholder engagement and communications. The LHIN will ensure timely communication of all priority information.

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Key Enablers | IT and IM are key enablers to achieving the Central West LHIN's four strategic directions outlined in IHSP 2016-2019. Accountabilities and responsibilities must be clear among stakeholders, and change management practices/tools should be in place to support effective adoption.

Ongoing partnerships with neighbouring LHINs, delivery partners, and HSPs will enhance the ability to leverage regional solutions, and sustainability models must be created and communicated to HSPs and the LHIN in advance of committing to project implementation.

Connect and Inform

Community Engagement

IHSP Initiative Description | Outlined in the *Local Health System Integration Act (LHSIA)*, LHINs are to "engage the community of diverse persons and entities involved with the local health system about that system on an ongoing basis, including about the IHSP and while setting priorities."

Recognizing that the health care needs of local communities are best understood by those who live and work within them, the Central West LHIN has embraced this legislated responsibility, focusing on placing the needs of patients at the centre of their health care system.

As it relates to the development of IHSP 2016-2019, the Central West LHIN hosted a series of stakeholder consultations, including consultations within LHIN communities. More specifically, the LHIN met with over 250 residents at sessions hosted by LHIN-funded HSPs. Over 650 residents responded to telephone and online surveys. Over 150 governors and leaders from across the LHIN were engaged in the planning process through two LHIN-hosted forums, and LHIN CAGs, steering committees and networks were also engaged through the consultation process.

The manner in which all stakeholder groups were engaged as part of the IHSP 2016-2019 development is indicative of how the Central West LHIN has and will continue to embrace the need for effective community engagement. The Central West LHIN will continue to work with HSPs and community partners to further educate and inform residents of the LHIN about their local health care system. So too will the LHIN, in collaboration with HSPs and community partners, actively listen to the perspectives and input of residents of the LHIN as a means of informing the planning process.

Current Status | Community engagement is about helping LHIN residents better understand their local health care system. It is also about listening to their perceptions and needs, empowering them to be active participants in the planning process. To support the development of IHSP 2016-2019, the Central West LHIN conducted a community consultation study to gauge resident attitudes, opinions, and awareness of LHINs in general, their local health care system, and the Central West LHIN itself. This was the fourth such study to be completed in ten years.

While general awareness and familiarity with the LHINs has continued to grow over the past decade, an overwhelming majority of respondents indicated they want to hear more from the LHIN. This provides a unique opportunity for the LHIN to further connect with local residents, helping them to better understand not only the LHIN itself but the health care system on the whole. Enabling them to become active participants in the planning and design of their local health care system, enhanced engagement will also provide residents with additional opportunities to share their valuable perspectives into LHIN activities.

Alignment with Government Priorities | Community engagement can be woven through all four objectives identified within Ontario's *Patients First:* Action Plan for Health Care. The action plans identified below will support the objectives of *Patients First*, and support health system collaboration through the use of effective community engagement.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status		Status	%
Develop a standing Central West LHIN citizen panel to access the perspectives of local citizens to generate conversations about the development of health care services in the LHIN and the LHIN's activities.	In progress	80	Ongoing			
Conduct regular polls to provide ongoing input into LHIN and HSP initiatives from diverse perspectives.	In progress	33	Ongoing			
Implement a marketing and communication strategy to increase awareness of health services available to residents in Central West LHIN.	In progress	33	Ongoing			
Work with local Public Health departments to promote healthy life decisions and personal responsibilities to maintaining good health.	In progress	33	Ongoing			

Expected Impacts of Key Action Items (How we will measure success?)

- The ongoing engagement of a fully functioning Citizen's Panel, that provides the LHIN with additional resident perspectives into LHIN activities throughout the duration of IHSP 2016-2019.
- Continuous improvement of results obtained from further deployment of the Community Consultation Study, designed to gauge resident perceptions and awareness of the local health care system and Central West LHIN.
- Continuous improvement of results obtained from further deployment of the Health Service Provider (HSP) satisfaction survey, designed to gauge perceptions and awareness of the relationship that exists between HSPs and the LHIN.
- Ongoing deployment of communications tools currently being used by the Central West LHIN to communicate with local residents of the LHIN about LHIN activities including:
  - Monthly eNewsletter "Working Together for Healthy Change"
  - Semi-Annual publication of LHIN progress through "Community Update"
  - Semi-Annual Tele Town Hall (in collaboration with regional partners).

Risks/Barriers to Successful Intervention

Risk	Mitigation Strategy
Changing Landscape | As the provincial health care system moves through the next phase of its transformation journey, and the role of the Central West LHIN evolves, it is expected that change management will become an important communications function within the context of community engagement.	As the provincial health care system continues to transform, the Central West LHIN will remain mindful of the expectations required of the communications function, and of the need to remain nimble and fluid with respect to its structure, if and when the LHIN environment begins to evolve.

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Key Enablers \| ABP 2016/17 further outlines a Communications and Community Engagement plan in Section 4. Please refer to Section 4 for further information.

French Language Services

IHSP Initiative Description | In collaboration with Reflet Salvéo, the French Language Health Planning Entity mandated to advise the LHIN on French language services (FLS), the Central West LHIN is committed to better understanding the needs of the francophone community, and to working in similar fashion with HSPs to ensure the needs of the francophone population are met.

To develop a continuum of care in French, the Central West LHIN will incorporate a FLS lens across strategic initiatives. The LHIN will work with system partners to improve the quality of data on the Francophone population, by supporting the development and use of common FLS indicators.

Current Status | The Central West LHIN currently has four HSPs identified for the planning and provision of a range of health care services in French. In addition to these four agencies, the LHIN also funds a specific seniors health promotion program. Together with Reflet Salvéo, these five agencies form the French Language Services CAG. The Central West LHIN will continue to promote the use of "active offer" in the planning and delivery of FLS across its health service providers.

In 2016-17, the LHIN will review both identified and non-identified HSPs to ensure they are appropriately classified, and meet the needs of the local Francophone community. It will assess whether there is a need and opportunity to identify additional HSPs to develop FLS plans.

Alignment with Government Priorities | The development of French Language Services align with all four objectives identified within Ontario's *Patients First:* Action Plan for Health Care. The action plans identified below will support the objectives of *Patients First*, and support the development of FLS that meet the needs of the local Francophone community.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Build on existing resources to plan for improved access and an "active offer" of FLS.	Ongoing					
Review plans of identified French language service HSPs to ensure plans are being implemented to improve access to FLS and to work towards designation.	Ongoing					
Review and reassess current HSPs who have been identified for FLS and ensure they are appropriate to meet the needs of the local Francophone community.	Not yet started	100	Completed			
Evaluate all local HSPs by sector and determine whether there are opportunities to identify additional HSPs to develop FLS plans to meet the needs of the local Francophone community.	Not yet started	50		25		25

Expected Impacts of Key Action Items (How we will measure success?)

- 100% of FLS Development Plans and Reports submitted from agencies identified for designation.
- Year over year increase in the number of functional centres reporting capacity to deliver French language services in identified agencies annual reports.

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
Lack of reliable system level indicators that produce data on FLS.	▪ The Central West LHIN will work with other system partners to develop common system level indicators.

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Key Enablers | The Central West LHIN uses provincial tables and local community committees to identify resources and best practices to guide its work on developing FLS. These include the FLS Coordinators Network, the Regroupement des Entités de Planification and the Table de Concertation Peel Halton Dufferin. It will also rely on the expertise of the Office des Affaires Francophones and the Office for French Language Services of the MOHLTC on designation.

Aboriginal Health

IHSP Initiative Description | The Central West LHIN will continue to engage local Aboriginal communities, with the aim of better understanding local health and service delivery issues from wellness to mental health, chronic disease management, and palliative care perspectives. The Central West LHIN is committed to building capacity within the health system to ensure Aboriginal communities receive culturally competent care; care that recognizes and is tailored to particular social, cultural, and linguistic needs.

Current Status | The Central West LHIN will continue to build on and strengthen relationships established with Aboriginal communities to better plan, fund, integrate, and monitor culturally competent services. The LHIN will continue to strengthen local partnerships with the Credit River Metis Council, the Dufferin County Cultural Resource Centre, and Peel Aboriginal Network to formalize the draft Terms of Reference for the Central West LHIN and Mississauga Halton LHIN Indigenous Advisory Health Circle. The LHIN will build culturally safe services through the continued roll out of Indigenous Cultural Competency online training course to both LHIN and HSP staff.

Alignment with Government Priorities | Planning for the local needs of Aboriginal communities will build upon work being done at the provincial level, including the Aboriginal Healing and Wellness Strategy, the 2nd phase of *Open Minds, Healthy Minds*: Ontario's Comprehensive Mental Health and Addictions Strategy, and the Provincial Aboriginal Leads Network's Annual Action Plan.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Continue to engage aboriginal communities through establishment of a formal structure for ongoing engagement.	Ongoing					
Deliver cultural competency training to HSPs with focus on aboriginal communities.	Ongoing					

Expected Impacts of Key Action Items (How we will measure success?)	
▪ Minimum of 5 HSPs that participate in Indigenous Cultural Competency (ICC) online training. ▪ Minimum of 15 HSP staff members training on Indigenous Cultural Competency. ▪ Minimum of 4 engagement activities held with the Aboriginal community.	
Risks/Barriers to Successful Intervention	
Risk	**Mitigation Strategy**
Difficulty recruiting participants for ICC Program.	▪ Use early adopters and champions of ICC to help promote the program.

[1]Per MOHLTC guidelines, the status of work (Not Yet Started, In Progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years. Percentages may not equal 100% due to work completed in previous fiscal calendar years, or work that is expected to carry forward beyond fiscal year 2018/19.

Key Enablers | The Provincial Aboriginal LHIN Network will provide resources and share key experience that will help the Central West LHIN strengthen its relationship with Aboriginal communities. Building on early adopters and champions of ICC will also facilitate the broader rollout of the program.

Demonstrate System Leadership

System Capacity Planning

IHSP Initiative Description | To support population health outcomes in a time of rapidly changing demographics and fiscal restraint, the Central West LHIN is responsible for identifying the existing capacity of, and resources required for, infrastructure, programs, people, and other elements that keep the health system running.

The Central West LHIN will use stronger connections with Public Health and the primary care sector, as proposed in *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario to better understand system capacity and population needs at the sub-LHIN level. This will guide the LHIN's planning and investments in community services that better meet the needs of the residents of the Central West LHIN.

Imbedded in the expansion of health system capacity is the province's commitment to develop community hubs, which conceptually unite cross-sector community organizations in a single, accessible location. The province has committed to developing these community hubs so that people can access a range of government services, including health and social services, in a single visit. Recognizing that there is no standardized framework for community hub development, the Central West LHIN will explore innovative models of development based upon the many emerging examples from across the province and abroad.

Current Status | Ensuring access to adequate services for a rapidly growing and aging population remains a priority for the Central West LHIN. In 2014/15, guided by recommendations in Dr. Samir Sinha's *Living Longer, Living Well* report, the Central West LHIN undertook a comprehensive, long-term Community Capacity Study of services for seniors. The study is the basis of a community health services plan to meet the needs of a growing and aging population by identifying current service gaps, challenges within in the system and opportunities for directing investments. The Central West LHIN will continue to assess and analyze service needs and resource capacity, guided by the study's recommendations.

Central West LHIN staff took part in a site visit of PACE programs and is currently working with the Region of Peel on the concept of a new seniors hub. Rudimentary seniors hubs currently exist at Holland Christian Homes in Brampton and at the Mel Lloyd Centre in Shelburne.

Alignment with Government Priorities | Dr. Sinha's 2012 report entitled "Living Longer: Living well" recommended that as part of redevelopment LTC homes could become part of seniors' hubs. The 2015 MOHLTC document *Patients First*: A Roadmap to Strengthen Home and Community Care calls for the creation of a capacity plan that will include targets for local communities and standards for access to home and community care. The LHIN will also align its work to ensure a more effective integration and greater equity of services as outlined in *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Complete capacity plans across services within the Central West LHIN in the context of provincial capacity planning initiatives.	In progress	50		30	Ongoing	
Using the completed capacity plan for seniors services, develop a local seniors strategy encompassing the various intersecting provincial and local renewal strategies.	In Progress	75	Completed			
Assess current HSP and community provider locations for potential co-location and opportunities to further develop community hubs.	In progress	50	Completed			

Expected Impacts of Key Action Items (How we will measure success?)
▪ Maintain an alternate level of care (ALC) rate at or below the provincial target. ▪ Average number of days waited for first service by Community Support Service (CSS).

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
Different IM/IT infrastructures may create barriers and add costs to the creation of community hubs and colocation opportunities.	▪ Work with health service providers to understand and address challenges at beginning of planning.
Duplication of efforts on certain work in initial partnering with public health.	▪ Build a strong relationship with public health and ensure there is open communication to avoid duplication.

[1]Per MOHLTC guidelines, the status of work (Not Yet Started, In Progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years. Percentages may not equal 100% due to work completed in previous fiscal calendar years, or work that is expected to carry forward beyond fiscal year 2018/19.

Key Enablers | Advances in telemedicine technology allows for greater connectivity with experts. OTN Connect technology should be exploited to support seniors hubs. Seniors care is delivered by multiple care providers in multiple settings. Access to health records by all care providers is essential to prevent seniors and/or their care givers from having to repeat their history multiple times. Use of the REACH and IAR tools in seniors' hubs will support this.

Population Health

IHSP Initiative Description | The Central West LHIN is committed to improving population health with a particular focus on applying a diversity and health equity lens to match services to need. As outlined in *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario, the LHIN will work with Public Health and health system partners, cross-sector public partners and the LHIN's Diversity and Health Equity CAG to identify specific local strategies to promote equitable access to patient-centred health care services.

Current Status | The Central West LHIN is an ethno culturally diverse community and a region of increasing income disparity. These characteristics have significant implications for the health of the local population and the health care system. When either groups or individuals face barriers to access and receive a lower standard of care, this leads to poorer health, greater strain on limited health care resources and ultimately higher costs for worse outcomes.

To date, the LHIN has established the Diversity and Health Equity CAG comprised of funded providers that are looking to explore and apply effective ways to improve cultural competency and minimize gaps for vulnerable populations. One of the key ways to increase awareness and identify practical ways to improve effectiveness of local programs is the introduction of the Health Equity Impact Assessment (HEIA) tool.

The LHIN continues to train providers on the use of the tool to integrate a health equity lens in program planning, implementation and evaluation. In addition, the Central West LHIN Diversity and Health Equity CAG endorsed the use of a cultural competence training modules created by SickKids, and funded by Citizenship and Immigration Canada. Use of these modules is being integrated into educational curricula at acute care hospitals. Hospital and community sector providers have also submitted Health Equity Plans to the LHIN and will continue to report on the implementation of these plans on a yearly basis.

The LHIN is actively working with health system partners to gain a current understanding of the effective collection and analysis of sociodemographic data to improve program effectiveness and future planning and improved access and quality of health care services. The approach to improving the health of the LHIN's neighbourhoods also requires a closer analysis of socio-economic status to inform strategies to minimize health disparities among the LHIN's vulnerable and marginalized populations. The Central West LHIN has begun the process of cross-referencing health care utilization data with socio-demographic information at a sub-LHIN level in an effort to identify sources of inequity in the spatial accessibility of health care services. There is also a proactive approach to connect with cross sector partners such as public health units and the local immigration partnerships to ensure a comprehensive approach to health equity and population health.

Alignment with Government Priorities | MOHLTC and LHINs have a legal and ethical responsibility to integrate equity considerations into planning and decision making. These have been outlined in the Canada Health Act, Future of Medicare Act, Charter of Rights and Freedoms and the Ontario Human Rights Code.

While most of the levers for the Social Determinants of Health lie outside of the purview of the MOHLTC and LHINs, there is momentum in looking at the health care system to better meet the needs of populations at risk for poor health by increasing access and quality of care. Addressing health equity has also been noted as making critical contribution to health system sustainability by reducing the incidence of costly and preventable illnesses and related treatments. Currently the MOHLTC is looking to gather current state information on health equity work to date and support provincial strategies to improve equitable access to high quality, patient-centred services.

Action Plans/Interventions[1]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Through the Healthy Communities initiative in the Central West LHIN bring together health and social services to broaden perspective for action based on the social determinants of health.	In Progress	50		25	Ongoing	
Work with public health and others to conduct an analysis of population health status and identify characteristics of sub-LHIN regions/ neighbourhoods to determine service access issues.	In Progress	60		30	Ongoing	
Engage health service providers and system partners in the development of the Central West LHIN's Health Equity Charter to ensure alignment and commitment of the acute care, community care and public health sectors in achieving common goals to increase equitable access to care.	In Progress	60		30	Completed	
Collect sociodemographic data of residents who enter the healthcare system to monitor the quality and equitable access to care from an organizational level and system perspective.	Not Yet Started	50		50	Ongoing	

Expected Impacts of Key Action Items (How we will measure success?)

In providing services through a Health Equity lens, we will achieve better access, better value and better quality of care for all residents in the Central West LHIN.

- Increase compliance with submitting Health Equity Progress reports as specified in their Service Accountability Agreements (SAAs).
- Analyze regional programs by postal code to implement targeted strategies.
- Establish a baseline and target to improve access to regional programs i.e., Telehomecare by 5% by 2016/17.
- Confirm commitment of local health care leaders through the signing of the LHIN's Health Equity Charter.
- Develop a cross sector systems approach to improving health equity in order to improve population health.

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
Lack of reliable data on the use of health care services by members of specific communities limits local knowledge of service use among diverse populations.	▪ The Central West LHIN will focus on monitoring and tracking available data that captures residents' access to and use of services by race, culture, language and gender. ▪ Central West LHIN staff will engage with CIHI to gain access to data to understand neighbourhood profiles in order to match services to need.
Service and resource pressures driven by population growth may deflect attention away from specific needs of high-risk communities.	▪ Integrate the health equity lens in Health Links implementation and roll out to ensure the needs of complex patients from various diverse groups are being met.

[1]Per MOHLTC guidelines, the status of work (Not Yet Started, In Progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years. Percentages may not equal 100% due to work completed in previous fiscal calendar years, or work that is expected to carry forward beyond fiscal year 2018/19.

Key Enablers | The Central West LHIN's Diversity and Health Equity Core Action Group will build on established relationships by inviting cross-sector partners to the table, and will work with provincial organizations such as HQO to embed health equity in its work. Strong leadership will also enhance cooperation and engagement amongst the diverse partners and active participation to develop cross sector strategies that improve the social determinants of health for the local population.

Dementia Strategy

IHSP Initiative Description | Dementia is a general term that refers to a variety of brain disorders. Physical changes in the brain cause dementia. In Ontario today, one in ten seniors are living with some form of dementia, including the most prevalent: Alzheimer's disease. That's nearly 200,000 people over the age of 65. As the baby boomer population ages, that number is expected to increase dramatically to 300,000 by the end of 2017.

Current Status | The Central West LHIN funds a Behavioural Supports Ontario (BSO) program with resources in every long term care home supported by regional psychogeriatric resource consultants. There is also a small resource available to support community-based agencies.

First Link® is a program for people with dementia and their caregivers. It offers information about dementia and links people with dementia and their caregivers directly to programs and services in their own communities. There are two First Link Programs in the LHIN operated by the Alzheimer Society and referrals can be made by health professionals or individuals. The Alzheimer Society also operates a day program in Brampton specifically for people living with dementias.

Memory clinics are important assets for early identification and care for people suffering from dementia. The Central West LHIN has two memory clinics.

Alignment with Government Priorities | Ontario's *Patients First:* Action Plan for Health Care calls for an improvement in dementia support. The 2012 Sinha Report called for additional resources for First Link programs. The MOHLTC is currently developing a province-wide dementia strategy which is expected to be released in 2016.

Action Plans/Interventions[1]	2016/17		2017/18	2018/19		
	Status	%	Status	%	Status	%
Lead the local implementation of the provincial dementia strategy.	Not Yet Started	40		30		25
Lead the development of an integrated psychogeriatric support for BSO.	In Progress	50		20		20

Expected Impacts of Key Action Items (How we will measure success?)
▪ Monitor admissions to hospital for dementia-related conditions. ▪ Decrease the number of Form 1 admissions to ED from LTC. ▪ Minimize the rate of ALC to LTC designations as a result of responsive behaviours. ▪ Increase the proportion of Health Links plans for people with dementia.

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
Rapid growth in the seniors population outstrips capacity to provide high quality dementia care.	▪ Conduct a capacity plan and update it regularly.
Transportation availability. Reliable and timely transportation services are needed to support vulnerable people to live at home longer.	▪ Transportation service needs will be integrated into associated care plans for those requiring home and community care services.
Increased numbers of higher acuity people living with dementia being maintained in the community will lead to increased caregiver burnout.	▪ Expansion of planned and emergency respite options.

[1]Per MOHLTC guidelines, the status of work (Not Yet Started, In Progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years. Percentages may not equal 100% due to work completed in previous fiscal calendar years, or work that is expected to carry forward beyond fiscal year 2018/19.

Key Enablers | Strong linkages with Health Links will ensure that patients suffering from early onset dementia are directed towards programs that will support them in their homes. The Services for Seniors Core Action Group will play an important role in monitoring performance and exploring possibilities. Hospital support to community agencies directly and via telemedicine will enhance the capacity to maintain people living with dementia in their own homes.

Care for caregivers is essential to support home and community dementia care. Programs that support emergency and planned respite care will form an important part of the care community. Building capacity within existing community agencies will promote integrated teams and will better support persons living with dementia and their care givers.

Dementia care is delivered by multiple care providers in multiple settings. Access to health records by all care providers is essential to avoid a patient and/or their care giver having to repeat their history multiple times. Use of the REACH and IAR tools by dementia care providers will avoid this.

Build on the Momentum

IHSP Initiative Description(s)

Women and Children's Health | The Central West LHIN is working with local providers to improve the quality of, and access to, women and children's health services, while at the same time aligning its work with provincial initiatives. The LHIN is primarily focused on improving access to and coordination of services for children with special needs and children with medical complexities.

Rehabilitative Care Alliance | The Rehabilitative Care Alliance (RCA) is a provincial collaborative established by Ontario's 14 LHINs in April 2013 to effect positive changes in rehabilitative care that focus on supporting improved patient experiences and enhancing the adoption and effectiveness of clinical and fiscal priorities. The RCA has developed provincial consensus on the definitions of rehabilitative care. The objectives in developing a provincial definitions framework were to:

- establish provincial standards for levels of rehabilitative care across the continuum
- provide clarity for patients, families and referring professionals on the focus and clinical components of rehabilitative care programs
- provide a foundation to support system and local capacity planning within the context of specific patient and local/regional programming needs through a common understanding of rehabilitative care services.

Cardiac Care Network and the Ontario Stroke Network | The Cardiac Care Network of Ontario (CCN), funded by the MOHLTC, works with hospitals in Ontario to plan, coordinate, implement and evaluate cardiac services across the province. CCN is also responsible for developing, maintaining and reporting on the provincial cardiac wait list registry for all patients waiting for select adult advanced cardiac procedures in the province. In the role of monitoring and enhancing quality of cardiac services in Ontario, CCN develops strategies, based on best practices, to better manage cardiovascular disease across the continuum of care, including strategies to prevent acute hospital readmissions, decrease demand on emergency departments and decrease the need for initial and repeat procedures.

The Ontario Stroke Network (OSN) provides provincial leadership and coordination for Ontario's 11 Regional Stroke Networks that support the 14 Local Health Integration Networks (Ontario Stroke System) by recommending, implementing, and evaluating province-wide goals and standards for the continuum of stroke care, including health promotion and stroke prevention, acute care, recovery and reintegration. It is funded by the MOHLTC.

Current Status

Women and Children's Health | The Central West LHIN works with the Provincial Council for Maternal Child Health (PCMCH) to improve access to care for children with medical complexities. The LHIN is also currently involved in the development of the local Special Needs Strategy for Peel and Dufferin in alignment with a provincial strategy to improve services for children and youth with special needs in Ontario. This requires working with providers that are funded by the Ministry of Child and Youth Services, Ministry of Community and Social Services, Ministry of Education, and MOHLTC.

Rehabilitative Care Alliance | LHIN implementation of the definitions framework includes:

- A LHIN review of current rehabilitative care resources relative to the definitions framework
- LHIN-level adoption of new terminology, eligibility criteria and re-categorization of rehabilitative care resources according to the levels of rehabilitative care in the definitions framework
- Identification of any challenges/barriers in achieving full alignment with the definitions framework by March 2017
- Where full re-alignment has not been achieved by the end of this mandate, there will be an implementation plan established by LHINs with support as required from the RCA.

Cardiac Care Network and the Ontario Stroke Network | CCN and OSN are currently in merger talks.

At present, CCN will continue to work closely with Ontario hospitals to provide leadership for monitoring and managing patient access to cardiac services in Ontario, using skills in information sharing, knowledge translation, and collaboration with key stakeholders at the hospital, regional and provincial levels to identify strategies for best practices and system improvements.

In addition, CCN will focus on issues pertaining to quality, efficiency, access and equity of advanced cardiac services, with ongoing evaluation of specific metrics and indicators of system performance. CCN is pleased to continue to serve as an advisory body to the MOHLTC in relation to the delivery of adult cardiac services in Ontario.

Alignment with Government Priorities | The Central West LHIN will align its initiatives for a more seamless and coordinated health care system as outlined in the province's *Patients First:* Action Plan for Health Care and *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario.

Action Plans/Interventions[4]	2016/17		2017/18		2018/19	
	Status	%	Status	%	Status	%
Work with CCO to increase cancer screening rates and ensure access to services for residents in the Central West LHIN.	In Progress	30		30		30
Work with PCMCH to ensure adherence to best practice guidelines and reporting of the Better Outcomes Registry and Network (BORN) indicators.	In Progress	30		30		30
Confirm and support the local special needs strategy in Peel and Dufferin as a signatory.	In Progress	40		30	Completed	
Work with CCN to move the provincial and local agendas forward.	In Progress	30		30		30
Work with RCA to locally implement the provincial Definitions Framework.	In Progress	30		30		30

Expected Impacts of Key Action Items (How we will measure success?)

- Alignment of CCO resource and capacity to support cancer services and needs for Central West LHIN residents
- Adoption of best practice standards by health service providers as set by PCMCH
- Alignment of the Special Needs Strategy with the provincial agenda of PCMCH
- Adoption of the new terminology, eligibility criteria and re-categorization of rehabilitative care
- Stroke Report Card contains 19 metrics for stroke care. Show improvement in all metrics.

Risks/Barriers to Successful Intervention	
Risk	Mitigation Strategy
A continued sector by sector approach to children with special needs without more integration of Health Links strategy and the work of PCMCH.	▪ Ensure MOHLTC and PCMCH are more engaged with the development, implementation and roll out of Ontario's Special Needs Strategy to ensure alignment with Health Links.
Development of the local stroke system will require reconfiguration of inpatient units at the William Osler Health System.	▪ Support the William Osler Health System in the required transitions.
Adoption of the new bed classifications for rehabilitative care may have funding implications as rehabilitation beds and complex continuing care beds are currently funded at different rates.	▪ This is a province-wide issue. The LHIN will monitor the MOHLTC direction and work with local health service providers as changes are introduced.

[1]Per MOHLTC guidelines, the status of work (Not Yet Started, In Progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years. Percentages may not equal 100% due to work completed in previous fiscal calendar years, or work that is expected to carry forward beyond fiscal year 2018/19.

Key Enablers | The West GTA Stroke Network provides an important forum for the development of the local stroke system. The regional CCO Council and Steering Committee Meetings will enable the Central West LHIN and HSPs to participate in regional projects and programs.

LHIN Operations

Three-Year LHIN Operations Spending Plan

**subject to change pending implementation of the proposals outlined in Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario.*

LHIN Operations Spending Plan						
LHIN Operations Sub-Category ($)	2014/15 Allocation	2014/15 Actuals	2015/16 Actuals	2016/17 Planned Expenses	2017/18 Planned Expenses	2018/19 Planned Expenses
Salaries and Wages	2,356,810	2,405,407	2,479,707	2,497,992	2,498,994	2,525,034
EMPLOYEE BENEFITS						
HOOPP	235,680	237,698	239,988	244,999	245,099	247,703
Other Benefits	259,250	265,085	277,401	267,095	271,530	274,395
Total Employee Benefits	***494,930***	***502,783***	***517,389***	***512,094***	***516,629***	***522,098***
TRANSPORTATION AND COMMUNICATION						
Staff Travel	25,000	14,604	18,935	20,000	20,000	20,000
Governance Travel	20,000	10,978	10,442	15,000	15,000	15,000
Communications	75,000	41,032	43,681	63,000	63,000	63,000
Other	-	3,495	5,428	-	-	-
Total Transportation and Communication	***120,000***	***70,109***	***78,486***	***98,000***	***98,000***	***98,000***
SERVICES						
Accommodation	240,000	234,812	170,816	190,440	190,440	190,440
Advertising	20,000	17,015	24,470	20,000	20,000	20,000
Banking	100	123	99	100	100	100
Consulting Fees	99,388	100,859	174,467	160,788	155,251	123,743
Equipment Rentals	8,000	8,100	5,063	7,850	7,850	7,850
Insurance	7,000	6,749	5,067	5,031	5,031	5,031
LSSO Shared Costs	342,000	328,153	283,166	283,419	283,419	283,419
LHIN Collaborative	47,500	39,018	35,242	34,069	34,069	34,069

Other Meeting Expenses	20,000	33,710	25,296	40,000	40,000	40,000
Board Chair's Per Diem Expenses	72,800	48,300	33,925	50,929	50,929	50,929
Other Board Members' Per Diem Expenses	92,300	57,600	54,089	75,818	75,818	75,818
Other Governance Costs	30,000	39,375	26,219	24,643	24,643	24,643
Printing and Translation	50,000	33,901	35,885	50,000	50,000	50,000
Staff Development	46,000	38,591	50,489	46,000	46,000	46,000
Total Services	***1,075,088***	***986,306***	***924,293***	***989,087***	***983,550***	***952,042***
IT Equipment	***20,000***	***36,855***	***47,705***	***20,000***	***20,000***	***20,000***
Office Supplies & Purchased Equipment	***45,000***	***82,655***	***59,976***	***39,655***	***39,655***	***39,655***
Total Supplies and Equipment	***65,000***	***119,510***	***107,681***	***59,655***	***59,655***	***59,655***
Capital Expenditures	***70,000***	***51,037***	***-***	***25,000***	***25,000***	***25,000***
LHIN Operations: Total Planned Expense	***4,181,828***	***4,135,152***	***4,107,556***	***4,181,828***	***4,181,828***	***4,181,828***
Annual Funding Target	***4,181,828***	***4,181,828***	***4,141,828***	***4,181,828***	***4,181,828***	***4,181,828***
Surplus	***-***	***46,676***	***34,272***	***-***	***-***	***-***
INITIATIVES SPECIFIC FUNDING						
French Language Services	106,000	104,870	106,000	106,000	106,000	106,000
Annual Funding Target	106,000	106,000	106,000	106,000	106,000	106,000
French Language Services Surplus	-	1,130	-	-	-	-
Diabetes Regional Coordination Centre	856,301	781,301	747,855	839,175	839,175	839,175
Annual Funding Target	856,301	728,517	839,175	839,175	839,175	839,175
Diabetes Regional Coordination Centre Surplus	-	52,784	91,320	-	-	-
Aboriginal Community Engagement	7,500	6,610	5,278	7,500	7,500	7,500
Annual Funding Target	7,500	7,500	7,500	7,500	7,500	7,500
Aboriginal Community Engagement Surplus	-	890	2,222	-	-	-
ER/ALC, Performance Lead	100,000	100,000	100,000	100,000	100,000	100,000
Annual Funding Target	100,000	100,000	100,000	100,000	100,000	100,000
ER/ALC, Performance Lead Surplus	-	-	-	-	-	-

Three-Year LHIN Staffing Plan

Staffing				
Position Title	2015/16 Actuals FTEs	2016/17 Forecast FTEs	2017/18 Forecast FTEs	2018/19 Forecast FTEs
1. Board and CEO Liaison	**1**	1	1	1
2. CEO	**1**	1	1	1
3. Director, Communication and Community Engagement	**1**	1	1	1
4. Director, ER/ALC/Decision Support	**1**	1	1	1
5. Director, Funding and Allocation	**2**	2	2	2
6. Director, Health System Integration	**5**	5	5	5
7. Director, Performance & Accountability	**1**	1	1	1
8. Director, Quality	**1**	1	1	1
9. Executive Assistant	**2**	2	2	2
10. French Language Services Coordinator and Aboriginal Health Consultant	**1**	1	1	1
11. Health System Integration Specialist	**1**	1	1	1
12. Health System Integration and Quality Improvement Specialist	**1**	1	1	1
13. LHIN Operations Manager	**1**	1	1	1
14. Senior Director, Health System Integration	**1**	1	1	1
15. Senior Director, Health System Performance	**1**	1	1	1
16. Specialist, Decision Support	**2**	2	2	2
17. Specialist, Performance	**1**	1	1	1
18. Specialist, Performance & Integration	**1**	1	1	1
19. Specialist, Performance & Quality	**1**	1	1	1
20. Administrative Assistant, Health System Integration	**2**	2	2	2
21. Support Analyst	**1**	1	1	1
22. **Total FTEs**	**29**	**29**	**29**	**29**

Communications & Community Engagement

Ontario's health care system has evolved to a point where LHINs are recognized for their leadership role in driving local health system transformation.

Consequently, with Ontario's *Patients First*: Action Plan for Health Care as a guide, the Central West LHIN has a critical role to play in moving key provincial initiatives forward including the following pan-LHIN priority areas: Health Links / Primary Care, Home and Community Care, Mental Health and Addiction Services, Palliative / End-of-Life Care, and Long-Term Care Redevelopment.

The following outline will be used to guide the communications and community engagement activities of the Central West LHIN Board of Directors and staff in support of IHSP 2016-2019 and ABP 2016/17.

Business Objectives

- Build integrated networks of care
- Drive quality and value
- Connect and inform
- Demonstrate system leadership

Communication Objectives

- Build confidence among residents of the Central West LHIN, that:
  - progress is being made to improve access to health services
  - progress is being made to improve the patient experience
  - the system is sustainable, being effectively managed, and providing value for tax dollars
  - the system is transparent.
- Increase health literacy to enable and support residents of the Central West LHIN to live healthy lives and manage their illnesses better.

- Engage providers, stakeholders and system leaders to become active participants in and ambassadors for transformation.
- Educate and build broad stakeholder awareness of Central West LHIN strategic directions and initiatives identified in IHSP 2016-2019 (above noted business objectives).
- Build ongoing support for an integrated sustainable local health care system that ensures better health, better care and better value for residents of the LHIN.
- Raise awareness of the Central West LHIN's role, its unique characteristics, value proposition, caliber and credibility of work, and importance within the local health care system.
- Educate and build awareness among HSPs regarding shared accountability for local health system transformation and the alignment of their respective initiatives with IHSP 2016-2019.
- Continue to build strong, trusted relationships with HSP communications teams across the Central West LHIN, working together to optimize communication resources and coordinated services.

Stakeholders

Depending on the situation, primary and/or secondary stakeholders (audiences) will include:

- Patients and Caregivers
- General Public
  - Residents
  - Community Organizations
- Health Service Providers, Health Care Professionals, community partners and, as appropriate, surrounding LHINs:
  - Leadership, front line staff and Boards of Directors as required
  - Physicians, clinicians, health care professionals, caregivers (paid /unpaid)
  - Consumer/patient support groups
  - Health care Associations (OHA, ONA, OMA, etc.)
- Government
  - Municipal
  - Regional
  - Provincial (including MOHLTC and other ministries as appropriate)
  - Federal
- Media
- Other LHINs

Strategic Approach

- Position the LHIN as a valued partner in the transformation of Ontario's health system.
- Position the LHIN as the leader of localized health system transformation.
- Position the work of the LHIN and local HSPs as a comprehensive and meaningful redesign of the way by which local health care needs are being heard, understood, addressed and met.

- Position the work of the LHIN as a model for "Healthy Change" that successfully breaks down barriers, encourages collaborative work, shares knowledge and fosters partnerships among local, regional and provincial agencies.
- Develop new opportunities to build the reputation and establish credibility of the Central West LHIN.
- Ensure that effective community engagement and input takes place at the most appropriate juncture(s) of a program or operational planning process that requires careful and comprehensive public consultation.

Tactics

- **Media -** In an effort to reach a variety of audiences, the Central West LHIN will seek to maintain and build upon existing relationships, while exploring new channels where deemed appropriate.
  - **Print:** When and as required, the Central West LHIN will issue appropriate and timely news releases, opinion editorials and matte stories to educate and inform communities regarding the current happenings and goings on the local health care system.
  - **Social / Online:** The Central West LHIN will look to formalize its presence with online/social media by devoting time and resources to establishing a formal social media policy, effectively managing new and existing content and committing to the development and use of interactive video content.
  - **Publications:** While the LHIN will continue to design and publish regular, targeted newsletters to a variety of stakeholders, their number, frequency and method of delivery will be reviewed to ensure they are meeting the needs of the intended audiences.

- **Stakeholder Events -** Whenever possible, the Central West LHIN Board and/or staff will participate in stakeholder engagement opportunities including but not limited to in-person town halls, telephone town halls, partner events, sponsored events, ground breaking ceremonies, facility openings, funding announcements, program/initiative announcements, and media opportunities.

- **Industry and Public Events/Conferences** – When and where deemed appropriate, the Central West LHIN Board of Directors and staff will continue to participate in key public health fairs and conferences at which they will have the opportunity to showcase LHIN activities, programs, achievements and successes.

- **Regional and Municipal Councils, and MPP Contact** - The LHIN will continue to meet regularly and communicate with regional, municipal and civic councils and MPPs across the area, to update them on achievements at the LHIN and to provide context on how work being done might impact their specific constituencies.

- **Brand Leveraging** – As local residents experience their health care system through their Health Service Providers, the Central West LHIN will seek to further leverage the brands and communication channels of key partners in order to more effectively deliver LHIN messages and information to local residents.

Key Messages

While different situations and issues will require specific messaging appropriate to the circumstances in which they arise, overall key messages should be adopted throughout the Central West LHIN's Communications & Community Engagement approach. They include:

Ontario's *Patients First*: Action Plan for Health Care

- Patients First means a caring, integrated experience for patients and faster access to quality health services for all Ontarians.
- Ontario's *Patients First*: Action Plan for Health Care sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre of our health care system by improving the health care experience:

  Access
  Improve access - providing faster access to the right care.

  Connect
  Connect services - delivering better coordinated and integrated care in the community closer to home; providing better home and community care.

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

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

- As the next logical step in the Patients First action plan, Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario proposes a path toward providing better access to care no matter where you live by better connecting health care services.

Local LHIN Messages

- The Central West LHIN has a strategic and operational plan to ensure local residents have access to high-quality, localized care, and a sustainable health care system for years to come.
  - By organizing the system differently and focusing on the medical evidence, the LHIN provides local residents with better care, better health and better value for their tax dollars.
  - The Central West LHIN recognizes that the system looks different in the communities across the area. The LHIN builds on these differences because they reflect the diverse needs of local communities.
- Together with local partners, the Central West LHIN continues to bring about significant and positive change to ensure better patient outcomes.
  - The Central West LHIN maintains accountability and performance agreements with the MOHLTC and local HSPs. These agreements outline in detail, targets to be achieved within agreed time frames to ensure that the quality of care for residents in the LHIN is maintained to the highest-possible standards.

- Bringing together local HSPs around the same table has been a critical step in creating a common vision of achieving a system that is built around patients and their communities, not providers themselves.

- The Central West LHIN is committed to building a more seamless and coordinated approach to patient care.
  - Silos, fragmentation, duplication and gaps in service delivery can have a dramatic impact on patient outcomes and people's experience with the health system. This is why the Central West LHIN has made it a strategic priority to streamline transitions and navigation across and throughout the health care system.

- The Central West LHIN is improving value in the system by identifying opportunities for local service providers to work better together to reduce duplication and delays, and avoid unnecessary costs.
  - Prior to the LHIN, many health care agencies and organizations worked separately in silos that created gaps in which patients were often left frustrated and confused about how and where to get the best care. The Central West LHIN has improved coordination among providers, with an emphasis on transition points, so that patients are transferred more smoothly and effectively from one sector of care to another.
  - Through performance agreements with the LHIN, health service providers in this region are being held accountable for the ways in which they provide quality driven, evidence based health care.
  - The Central West LHIN is a leading organization that will strengthen primary health care through the establishment of Health Links and the bolstering of community-based health care services.

Communication Tools

Tools	Timeline(s)	Responsibility	Context
News Releases	As required, to highlight/promote Central West LHIN activities/events.	Communications	In conjunction with program areas as required.
Success Stories	Support timely/effective impact of good news on appropriate audience(s).	Program Leads	Program areas will "feed" material to Communications.
eNews	Monthly newsletter to a general audience.	Communications	Info and fact-checking by program area.
Community Update	Semi-annual publication to recap and check in on progress made throughout the fiscal year.	Communications	Info and fact-checking by program area.
MPP / Municipal Briefing Notes (Updates)	Sent to MPP's and municipal leaders monthly.	Communications	Fed from monthly CEO update to the Board.

MPP Meetings	Quarterly	Central West LHIN Board Chair and CEO	With support from communications.
Governance and Leadership Forums	Quarterly	Communications	Support provided to Board of Directors.
Regional, Municipal, Civic Council Meetings	Meet/present to these bodies regularly, contingent on schedule availability.	Central West LHIN Board Chair and CEO	With support from communications.
Conferences	As appropriate.	Relevant program area aligned to topic or theme of event.	None.
Speakers bureau (opportunities)	As appropriate.	CEO, Senior Directors to identify opportunities	Speaking notes supplied by Communications as required.
Board Materials	Ahead of and following monthly Board meetings.	Board and CEO Liaison	None.
Media Outreach – Print, Broadcast, Online	Ongoing	Communications	Participation by program area(s) for background and/or education.
Website – Content Management and Updating	Ongoing	Communications	Preparation and postings of materials to be handled by program area, with vetting by Communications to ensure messaging content and tone.
MOHLTC Requests for information/ analysis	As required. Usually on immediate turnaround.	Communications to coordinate with input from program areas.	None
French Language Services (FLS) coordination	As required to further Central West LHIN and/or Reflet Salvéo with communications plans.	FLS Coordinator, with assistance from Communications	None

Evaluation

Identifying and tracking communication success factors enables the Central West LHIN to more effectively identify whether communication activities have been successful. Using the following measures, a formal and comprehensive evaluation of the LHIN's communications efforts will be carried out in-house.

- Tone and volume of editorial coverage: this information will be collected and evaluated within a context of transparent disclosure.
- Website traffic: using analytics, pages and specific postings are tracked.
- Evaluate LHIN community engagement by monitoring and measuring tone and volume of traditional media, online/social media, and LHIN communication vehicles (emails, bulletins).
- Event participation and feedback.
- Visible senior leadership engagement and support for the communications & community engagement activities associated with the IHSP 2016-2019 strategic directions and ABP 2016/2017 initiatives.
- Active participation of LHIN Board Members in support of communications & community engagement.
- A clear understanding, by key stakeholders, of the LHIN's strategic and operational plans, and how they play a role towards their successful realization.
- The appropriate, early and frequent engagement of HSPs to demonstrate how their ongoing participation impacts successful realization of desired outcomes.
- The level and frequency of resident engagement by and with the Central West LHIN using a variety of instruments, including traditional media, online/social media and LHIN communication vehicles.
- The use of feedback mechanisms and ongoing assessment tools to monitor the effectiveness of communication vehicles and messages.

BOARD OF DIRECTORS

Maria Britto *
Chair
June 9/11 – June 8/14
June 9/14 – June 8/17

Hon. John McDermid *
Vice Chair
June 9/11 – June 8/14
June 9/14 – June 8/17

Adrian Bita
Director
May 6/15 – May 5/18

Lorraine Gandolfo *
Director
Oct. 27/10 – Oct. 26/13
Oct. 27/13 – Oct. 26/16

Suzan Hall *
Director
May 17/11 – May 16/14
May 17/14 – May 16/17

Gerry Merkley *
Director
June 17/10 – June 16/13
June 17/13 – June 16/16

Jeff Payne
Director
May 27/15 - May 26/18

Pardeep Singh Nagra *
Director
June 9/11 – June 8/14
June 9/14 – June 8/17

Ken Topping *
Director
Oct. 6/10 – Oct. 5/13
Oct. 6/13 – Oct. 5/16

** Denotes Reappointment*

NOTES

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The Central West LHIN Annual Business Plan 2016/17 is available in both English and French.