



ANNUAL **BUSINESS** PLAN 2018-2019

A **HEALTHier** Community for All



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GLOSSARY

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

ABP	Annual Business Plan	HRM	Hospital Report Manager
ALC	Alternate Level of Care	HSP	Health Service Provider
CAG	Core Action Group	HQO	Health Quality Ontario
CCAC	Community Care Access Centre	IAC	Indigenous Advisory Circle
CHC	Community Health Center	IHSP	Integrated Health Service Plan
CSS	Community Support Service	IM	Information Management
CWPCN	Central West Palliative Care Network	IT	Information Technology
ED	Emergency Department	LHIN	Local Health Integration Network
EMR	Electronic Medical Record	LHSIA	Local Health System Integration Act
FHG	Family Health Group	LTC	Long-Term Care
FHO	Family Health Organization	MOHLT C	Ministry of Health and Long-Term Care
FHT	Family Health Team	OTN	Ontario Telemedicine Network
FLS	French Language Service(s)	PACE	Program for All-inclusive Care for the Elderly
HEIA	Health Equity Impact Assessment	RQT	Regional Quality Table
HHCC	Headwaters Health Care Centre	SPO	Service Provider Organization



A Message from the Board Chair & CEO

The Central West Local Health Integration Network (LHIN) is pleased to present its Annual Business Plan (ABP) for fiscal year April 1, 2018 through March 31, 2019 (ABP 2018/19), identifying those activities it will undertake to support the final year of its current Integrated Health Service Plan (IHSP), [IHSP 2016-2019](#).

ABP 2018/19 builds on the LHIN's many accomplishments of the past year which, in support of Ontario's [Patients First Act](#) (the Act), included successful transition of the Central West Community Care Access Centre (CCAC) to the LHIN on May 31, 2017, and an expanded mandate to assume responsibility for the planning and delivery of home and community care services in our geographic area. With transition now complete, the important work of health system transformation has begun and will continue to define the LHIN's priorities throughout the coming year.

Designed to enable a more patient-centered health care system, the Act is an important component of the government's [Patients First: Action Plan for Health Care](#) (*Patients First*), supporting enhanced patient experiences and smoother care transitions by improving connections between primary care providers, inter-professional care teams, hospitals, public health, and home and community care. In 2018/19, aligned with *Patients First*, the Act and Minister Mandate Letter the Central West LHIN will continue to partner with patients and their families, the Ministry of Health and Long-Term Care (MOHLTC), other LHINs, health service providers (HSPs), service provider organizations (SPOs), community partners and health care innovators to improve the patient experience, increase access to care and reduce wait times – while working to reduce health disparities. With an eye to ensuring the best health outcomes for all, our collective focus throughout transformation will be to:

- Deliver care that reflects the patient voice and is responsive to patients' needs, values and preferences
- Address the root causes of health inequities and social determinants of health by investing in health promotion and reducing the burden of disease and chronic illness
- Create healthy communities for patients by improving access to primary care and reducing wait times for acute care, specialist care, mental health and addictions services and, home and community care
- Break down silos between health care sectors and providers to ensure seamless transitions for patients
- Support innovation by delivering new models of care and digital solutions to make accessing care easier for patients and more efficient for health care providers.

As we deliver on our mandate, we will also continue to maintain and strengthen the four key pillars that guide us:

- Promote health equity and reduce health disparities and inequities
- Respect the diversity of local LHIN communities including the promotion of culturally safe care for Indigenous people and meeting requirements contained in the *French Language Services (FLS) Act*
- Strengthen local engagement with Francophone and Indigenous communities
- Work with local partners to plan and deliver health services.

Ontario's health care system has improved significantly over the past decade but there is still more work to do. With 2018/19 marking final year of its current IHSP, the Central West LHIN will soon begin the important task of developing a new strategic plan to chart its future course. In the work that lies ahead, the LHIN remains committed to improving access, connecting services, supporting people and patients, and protecting the local health care system now and for future generations.

The LHIN's Board of Directors and staff thank our partners for helping to create meaningful change in our local health care system. It is only by working together that we can make the bold vision of *Patients First*, a reality.

Together, Building “A **HEALTHier** Community for All”



Carmine Domanico
Board Chair



Scott McLeod
CEO



Overview

Annual Business Plan (ABP) 2018/19 is the Central West Local Health Integration Network (LHIN) work plan for fiscal year April 1, 2018 through March 31, 2019, the final year of the LHIN's current Integrated Health Service Plan (IHSP), [IHSP 2016-2019](#). It builds on work previously completed and/or already in progress, taking into account activities designed to support the LHIN during a period of transformative change.

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, health and geographic) of local residents, and a summary of the LHIN's current and forthcoming programs and activities.

Section 2 | Health System Oversight and Management... Outlines key activities the Central West LHIN will undertake in 2018/19 to support the strategic directions of IHSP 2016-2019.

Section 3 | Home and Community Care... Outlines key activities, specific to Home and Community Care, that the LHIN will undertake in 2018/19 to support the strategic directions of IHSP 2016-2019.

Section 4 | French Language Services and Indigenous Peoples... Outlines key activities the Central West LHIN will undertake in 2018/19 to enhance the provision of health care services within Francophone and Indigenous communities.

Section 5 | Performance Measures... An overview of how the LHIN will measure its success in support of its mandate and priorities.

Section 6 | Risks and Mitigation Plans... A review of the unique health system planning challenges within the Central West LHIN and a high level overview of how the LHIN plans to address both current and future needs.

Section 7 | LHIN Operations... Provides the three-year spending and staffing plans for Central West LHIN operations.

Section 8 | Communications and Community Engagement... Describes Central West LHIN communications and community engagement goals, objectives and evaluation measures for the coming fiscal year.

In partnership with patients and their families, the Ministry of Health and Long-Term Care (MOHLTC), other LHINs, health service providers (HSPs), service provider organizations (SPOs), community partners and health care innovators the Central West LHIN is working to ensure a sustainable, high-quality and patient-centred health care system for current and future generations.

The LHIN's 2018/19 Annual Report will highlight the success of ABP 2018/19, chronicling the LHIN's accomplishments toward ensuring that patients and their needs remain at the centre of their local health care system.



Section 1 - Context

The Central West Local Health Integration Network (LHIN) was established under the [Local Health System Integration Act \(LHSIA\) - 2006](#), with the authority to plan, fund, integrate and monitor the local health care system for the purpose of improving the health of residents in the communities of Brampton, Caledon, Dufferin County, Malton, North Etobicoke and West Woodbridge.

With passage of the [Patients First Act](#) and transition of the Central West Community Care Access Centre (CCAC) to the Central West LHIN on May 31, 2017, the LHIN now has an expanded mandate for the planning and delivery of home and community care services within its geographic area.

To reflect its expanded mandate, the LHIN undertook a process to refresh its Mission, Vision and Values following transition.

■ Mission

Partnering to achieve excellence in health and health care.

■ Vision

A Healthier Community for All.

■ Values

- **Compassion**
 - We are empathetic, sensitive and kind in everything we do.
- **Innovation**
 - We challenge the status quo and develop new solutions that leverage technology, culture, strategy and leadership, and drive change.

■ Collaboration

- We foster cross-sectoral partnerships and cultivate relationships to promote and deliver improved health and health outcomes.
- We educate and encourage patients, families and caregivers to share their experiences to inform system-level solutions.
- We will create a culture of collaboration across our organization.

■ Accountability

- We are committed to the effective delivery of high quality, patient-centred, safe, and equitable care.
- We take responsibility as system stewards to ensure health system resources are used efficiently and effectively.
- We approach our relationships and organizational activities with honesty, integrity and transparency.

■ Respect

- We value and celebrate all realms of diversity in our community.
- We value our community's beliefs, cultures, and backgrounds.
- We are committed to creating a healthy workplace where everyone feels safe and valued.

■ Excellence

- We strive to deliver the highest quality service to residents in the Central West LHIN.
- We will continuously learn to help us achieve service excellence in everything we do.

■ Strategic & Operational Alignment

Meeting the complex health care needs of a rapidly growing, aging and culturally diverse population requires evidence-based local planning. It also requires an ability to address broader provincial priorities.

Annual Business Plan (ABP) 2018/19 is the Central West Local Health Integration Network (LHIN) work plan for fiscal year April 1, 2018 through March 31, 2019. It identifies specific activities the LHIN will undertake to support work that is to be accomplished during the third and final year of the LHIN's current Integrated Health Service Plan (IHSP), [IHSP 2016-2019](#). More specifically, it focuses on work that will be completed to advance each of the LHIN's four Strategic Directions including *Build Integrated Networks of Care*, *Drive Quality and Value*, *Connect and Inform*, and *Demonstrate System Leadership*. In addition, it places a spotlight on specific activities designed to advance its newly expanded mandate for the planning and delivery of home and community care services.

Rooted in the common vision of Ontario's [Patients First: Action Plan for Health Care](#) (*Patients First*), [Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario](#), [Patients First: A Roadmap to Strengthen Home and Community Care](#) and common priorities identified in the Minister Mandate Letter,

the success of ABP 2018/19 will be documented in the Central West LHIN's 2018/19 Annual Report (AR 2018/19).



As it relates to priorities outlined in the Minister Mandate Letter, the Central West LHIN will:

Minister Mandate Letter Priorities	Central West LHIN Commitments
Transparency and Public Accountability	<i>The Central West LHIN will fund and deliver health care resources sustainably and effectively by:</i> – Refreshing the balanced scorecard and developing a performance management framework.
Improve the Patient Experience	<i>The Central West LHIN will improve the patient and caregiver experience by:</i> – Engaging the Central West LHIN Patient and Family Advisory Committee (PFAC) to support health planning – Measuring and reporting on patient experience and confidence measures.

Build Healthy Communities Informed by Population Health Planning	<i>The Central West LHIN will enhance population health planning by:</i> – Leveraging the Central West LHIN and Public Health Steering Committee to assess local population health needs and promote innovative and collaborative solutions – Developing sub-region community data profiles to support evidence-informed decision making at the local level – Expanding and scaling the multi-sectoral neighborhood-based Healthy Communities initiative.
Equity, Quality Improvement, Consistency and Outcome-Based Delivery	<i>The Central West LHIN will promote health equity considerations by:</i> – Championing the Central West LHIN Health Equity Charter across health and social service organizations – Completing health equity impact assessments for all initiatives at the sub-region level. <i>The Central West LHIN will ensure that safe and effective patient-centred care is consistently delivered by:</i> – Advancing priorities identified in the Central West LHIN 2018/19 Integrated Quality Plan – Advancing the priorities identified in the Central West LHIN 2018/19 Home and Community Care Quality Improvement Plan (QIP) – Supporting the implementation of relevant Health Quality Ontario (HQO) quality standards at the sub-region level.

Primary Care	<i>The Central West LHIN will increase timely access to primary care by:</i> – Completing sub-region primary care capacity assessments – Enhancing transitions of care through initiatives developed at the sub-region level – Increasing access to inter-professional care teams in each sub-region – Improving the connections between care coordination and primary care.
Hospitals and Partners	<i>The Central West LHIN will enhance patient flow across acute care and home and community care settings by:</i> – Implementing bundled care for rehabilitation services – Expanding the integrated care coordination model – Developing innovative patient flow initiatives – Supporting continuity of care and effective discharge planning – Enhancing Long-Term Care (LTC) Home patient supports and continuity of care when accessing hospital services.
Specialist Care	<i>The Central West LHIN will increase medically appropriate and timely access, consistency and integration of specialist care by:</i> – Expanding the Centralized Intake and Assessment Centre (CIAC) – Implementing the Inter-professional Spine Assessment and Education Clinic (ISAEC) at the sub-region level – Enhancing uptake of enabling technologies such as eReferral.

Home and Community Care	<i>The Central West LHIN will deliver high quality and consistent home and community care by:</i> – Implementing the Levels of Care Framework – Continuing alignment of care coordination with primary care – Expanding Health Links – Enhancing uptake of Telemedicine in primary care and home care settings – Continuing to expand Self-Directed Care – Continuing to implement wound care best practices – Exploring innovative models of community clinic service delivery – Enhancing the uptake of enabling technologies by leveraging provincial digital health assets.
Mental Health and Addictions	<i>The Central West LHIN will improve access to community mental health and addiction services by:</i> – Supporting the provincial Opioid Strategy with a local Opioid Services Strategy focused at the sub-regional level – Expanding access to psychotherapy services at the sub-region level – Continuing to implement the Supportive Housing Strategy.
Innovation, Health Technologies and Digital Health	<i>The Central West LHIN will advance health care related digital innovation through enhanced uptake and integration of:</i> – eVisit – eReferral – eConsult – eShift – Telehomecare

Long-Term Care (LTC)	<i>In partnership with the MOHLTC, the Central West LHIN will strengthen the LTC home sector by:</i> – Continuing to advance LTC home renewal initiatives – Completing a LTC home capacity assessment – Planning for new LTC bed licenses.
Dementia Care	<i>The Central West LHIN will increase support for individuals living with dementia and their care partners by:</i> – Utilizing the Dementia Capacity Planning framework to complete a needs assessment at the sub-region and LHIN level – Developing a Regional Dementia Strategy with a focus on supporting people with dementia and their care partners, developing a local workforce, and raising public awareness.

■ The Central West LHIN Landscape

Population Profile

Over the past decade the Central West LHIN has grown substantially, from 740,000 residents in 2006 to over 922,000 in 2015¹. Representing an increase of 25 per cent, LHIN residents now account for seven percent of Ontario's total population². With the highest projected growth rate in the province, at over 17,000 new residents each year³, the LHIN's population is expected to grow to almost 1.1 million by 2025⁴.

¹ Environmental Scan, 2016-2019 Integrated Health Services Plan, Health Analytics Branch, Ministry of Health and Long-Term Care

² Environmental Scan, 2016-2019 Integrated Health Services Plan, Health Analytics Branch, Ministry of Health and Long-Term Care

³ IntelliHealth Population Projections Cube

⁴ Environmental Scan, 2016-2019 Integrated Health Services Plan, Health Analytics Branch, Ministry of Health and Long-Term Care

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 per cent, from 111,000 to 180,000⁵.

As one of the most geographically and culturally diverse LHINs in the province, the Central West LHIN has the highest visible minority population at 57 per cent⁶. Eighty-six percent of LHIN residents reside in urban areas, eight per cent in a suburban setting, and six per cent in rural communities⁷. Forty-seven percent of residents of the LHIN are immigrants, seven per cent of whom are new to Canada within five years⁸. Fifty-eight percent of all LHIN residents report English as their first language, the second lowest rate in the province, and four per cent of residents report no knowledge of English or French⁹. The LHIN is also home to over 12,500 residents whose first official language spoken is French¹⁰ and 5,600 residents who self-report as Indigenous people¹¹.

Health Profile and Access to Care

The Central West LHIN has the highest rates of diabetes amongst all LHINs, with a prevalence rate in 2016 of 15.7 per cent¹². Given the unique blend of unprecedented growth in the senior's population and increased proportions of high risk ethnic groups residing within the LHIN, the prevention and management of diabetes and other chronic conditions will continue to remain a local priority.

Timely and appropriate access to primary health care is a key objective of both *Patients First* and IHSP 2016/19. While 95 per cent of LHIN residents report having a regular primary care provider, only 53 per cent report the ability to see a primary care provider on the same or next day when sick¹³.

In 2016/17, residents in the Central West LHIN made 318,013 visits to emergency departments (ED) in Ontario¹⁴. Most of these visits (71 per cent) were to one of the three EDs and one urgent care centre (UCC) within the Central West LHIN¹⁵. At the same time, there were a total of 266,466 ED visits to Central West LHIN hospitals, including 5,840 visits to the new UCC at Peel Memorial Centre for Integrated Health and Wellness¹⁶. In 2016/17, Brampton Civic Hospital had the busiest ED in Ontario with eight per cent more visits than the next busiest ED (138,885 visits, as compared to 128,467 at the Humber River Hospital Wilson Site)¹⁷.

⁵ Environmental Scan, 2016-2019 Integrated Health Services Plan, Health Analytics Branch, Ministry of Health and Long-Term Care

⁶ National Household Survey 2011

⁷ Census 2011

⁸ National Household Survey 2011

⁹ Census 2011 (Note: Central LHIN has lower percentage reporting English as mother tongue at 52%)

¹⁰ Census 2011

¹¹ National Household Survey 2011

¹² Ontario Diabetes Performance Indicators 2017

¹³ Health Care Experience Survey (July 2016 to June 2017)

¹⁴ IntelliHealth NACRS (accessed 2017-11-09)

¹⁵ IntelliHealth NACRS (accessed 2017-11-09)

¹⁶ ER Fiscal Year Report September 2017 – Cancer Care Ontario

¹⁷ ER Fiscal Year Report September 2017 – Cancer Care Ontario

Hospitals in the Central West LHIN also had the lowest rate of visits best treated in alternative primary care settings, which suggests that the very high number of ED visits may be appropriate¹⁸. The 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.

In 2016/17, home and community care services were provided to over 42,000 patients, 63 per cent of whom received in-home services¹⁹. Of the 23,600 residents who received in-home services, 57 per cent were long-stay (received care for more than 90 days) and 38 per cent received two or more services (excluding care coordination)²⁰. In-home nursing services (visits) were provided to nearly 11,000 residents.

Sub-Region Profiles

In support of the *Patients First Act*, the LHIN has divided its geographical area into five planning areas known as sub-regions. These include Bolton-Caledon, Bramalea and Area, Brampton and Area, Dufferin and Area, and North Etobicoke-Malton-West Woodbridge. These smaller geographic planning areas are designed to help LHINs better understand and address patient needs at the local level. By looking at care patterns through a smaller, more targeted lens, system planners will be able to better identify and respond to community needs, and ensure that patients across the entire LHIN have access to the care they need, when and where they need it.



Having experienced nearly three per cent growth between 2011 and 2016²¹, the **Bolton-Caledon** sub-region has approximately 38,478 residents. Twenty-two per cent of the population live in rural communities²², twenty-one per cent are immigrants, less than one per cent are new to Canada within the last five years, and just under nine per cent are of a visible minority²³. Ninety-three per cent of residents report English as their most frequently spoken language in the home, and roughly one per cent report no knowledge of either English or French²⁴.



Having experienced nearly 15 per cent growth between 2011 and 2016²⁵, the **Bramalea and Area** sub-region has approximately 275,774 residents. Bramalea has one of the highest proportions of visible minority populations in the province at 72 per cent²⁶.

¹⁸ IntelliHealth, NACRS and Population Projections (accessed 2017-11-09)

¹⁹ Client Health and Related Information System, 2017

²⁰ Client Health and Related Information System, 2017

²¹ Census 2016

²² Census 2016

²³ National Household Survey 2011

²⁴ Census 2011

²⁵ Census 2016

²⁶ National Household Survey 2011

Fifty-three per cent of the population are immigrants, just over seven per cent are new to Canada within the last five years²⁷, sixty-four per cent report English as the most frequently spoken language in the home, and over five per cent report no knowledge of either English or French²⁸.



Accounting for the largest proportion of residents among the five sub-regions, thirty-six per cent (323,320) of Central West LHIN residents reside in the **Brampton and Area**

sub-region. At 60 per cent, Brampton has one of the highest proportions of visible minority populations in the province²⁹. Forty-eight per cent are immigrants, just over seven per cent are new to Canada within the last five years³⁰, seventy-four per cent report English as the most frequently spoken language in the home, and about four per cent report no knowledge of either English or French³¹.



Having experienced nearly seven per cent growth between 2011 and 2016³², the **Dufferin and Area** sub-region has approximately 74,303 residents. Forty-one per

cent of the population live in rural communities, the highest proportion among the LHIN's five sub-regions³³. Thirteen per cent are immigrants and approximately five per cent are of a visible minority³⁴. Dufferin and Area also has the highest proportion of residents who self-identify as Indigenous people.³⁵ Ninety-eight per cent report English as the most frequently spoken language in the home, and less than one per cent of residents report no knowledge of either English or French³⁶.



With the lowest population increase between 2011 and 2016 among LHIN sub-regions, at less than one percent growth³⁷, the **North Etobicoke, Malton, West Woodbridge**

(NEMWW) sub-region has approximately 200,365 residents. Less than one per cent of the population live in a rural setting³⁸. At 62 per cent³⁹, NEMWW has one of the highest proportions of visible minority populations in the province. Fifty-six per cent are immigrants, over nine per cent have arrived in Canada within the last five years⁴⁰, sixty-three per cent report English as the most frequently spoken

²⁷ National Household Survey 2011

²⁸ Census 2011

²⁹ National Household Survey 2011

³⁰ National Household Survey 2011

³¹ Census 2011

³² Census 2016

³³ Census 2016

³⁴ National Household Survey 2011

³⁵ National Household Survey 2011

³⁶ Census 2011

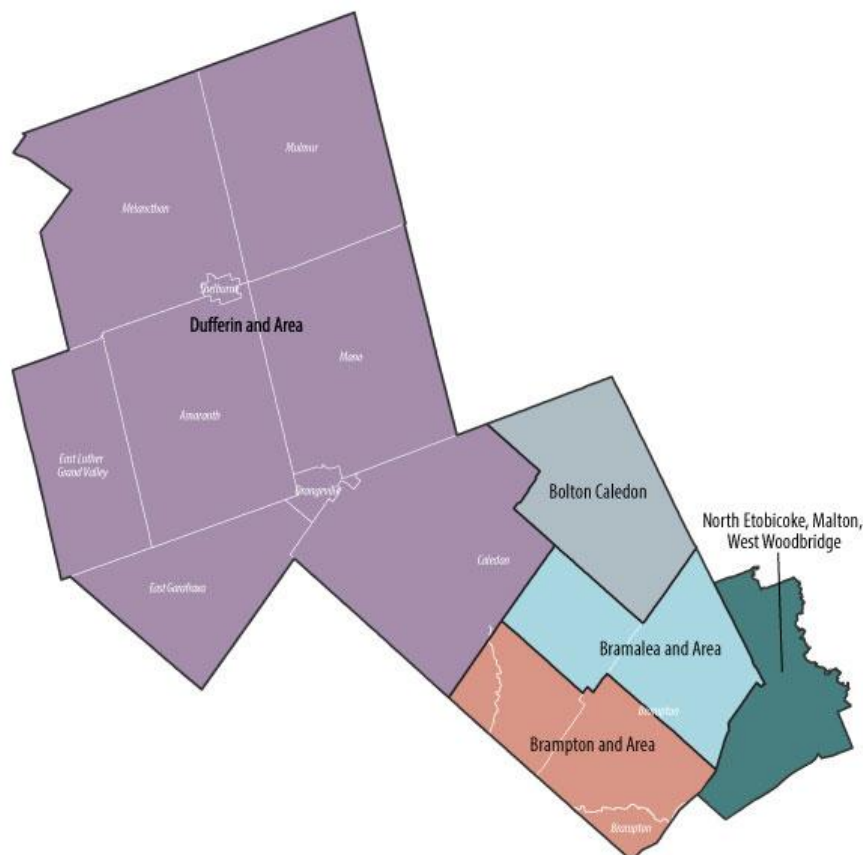
³⁷ Census 2016

³⁸ Census 2016

³⁹ National Household Survey 2011

⁴⁰ National Household Survey 2011

language in the home, and just over five per cent of residents report no knowledge of either English or French⁴¹. At 23 per cent, this sub-region has one of the highest proportions of children living in low-income measure after tax households in the province⁴².



■ Health Care Resources and Their Use

Over the past seven years a 27 per cent increase in base funding, totaling \$199 million (from \$727.4 million in 2019/10 to \$926.4 million in 2016/17), has resulted in improved access to a variety of health care programs and services in the Central West LHIN. Through a budget of \$926.7 million, provided by the MOHLTC, the LHIN funds health service providers (HSPs) and community partners in the LHIN's five sub-regions, including:

- Two hospital corporations across four sites that attend to over 58,000 hospital discharges⁴³ and over 266,000 ED visits per year⁴⁴
- Home and Community Care that serves over 42,000 patients per year⁴⁵
- Twenty-three LTC homes that provide an estimated 1,189,355 resident days per year

⁴¹ Census 2011

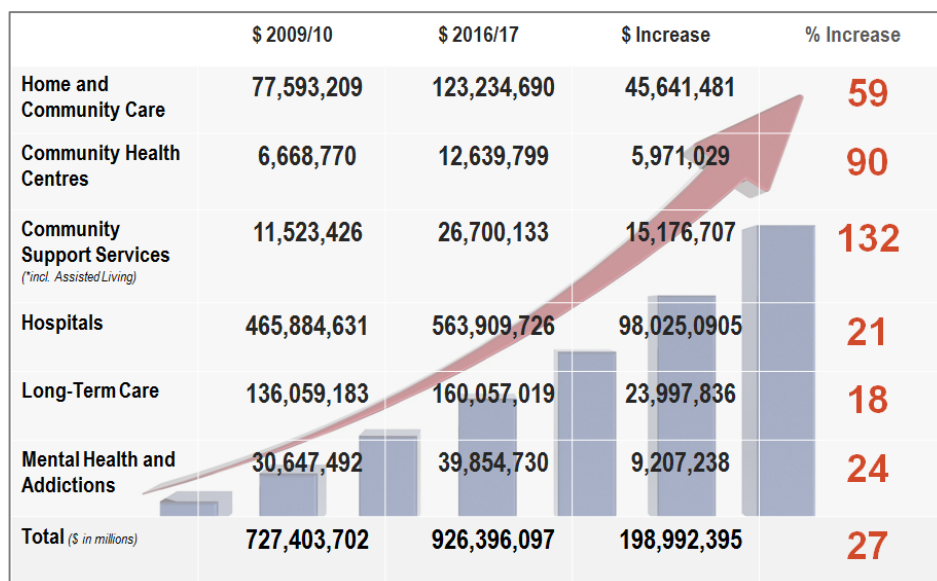
⁴² National Household Survey 2011

⁴³ IntelliHealth DAD (2017-11-09)

⁴⁴ IntelliHealth NACRS (2017-11-09)

⁴⁵ Client Health and Related Information System, 2017

- Two Community Health Centers (CHC) across five locations that deliver over 42,000 primary care visits per year
- Nineteen Community Support Service (CSS) agencies who offer services to over 20,000 clients per year
- Seven mental health and addictions organizations that provide over 350,000 interactions to local LHIN residents per year.



■ Current and Forthcoming Programs/Activities

The Central West LHIN is responsible for the planning, funding, integration and monitoring of health care services, including the planning and delivery of home and community care services, across its geographic region. With an eye to its overall mandate, the LHIN has been engaged in a variety of activities that support the strategic imperatives of IHSP 2016/19.

Build Integrated Networks of Care

Ensuring residents have timely access to high-quality, patient-centred care is central to the LHIN's Mission of partnering to achieve excellence in health and health care. The Central West LHIN remains committed to providing improved access to the right care, at the right time and in the right place.

This means better integration of existing resources into strong networks of care, investing in areas that require additional capacity to meet the needs of a rapidly growing and aging population, and looking for new and innovative ways to deliver care more effectively and efficiently to geographically and culturally diverse communities. This is accomplished by enhancing continuity of care both within and between primary care, health links, services for seniors, mental health and addictions, palliative care, and home and community care.

2018/19 Planned Activities

- Enhance transitions of care through initiatives developed at the sub-region level, including the expansion of Health Links



- Increase access to inter-professional care teams at the sub-region level
- Improve connections between care coordination and primary care
- Expand the Centralized Intake and Assessment Centre (CIAC)
- Implement the Inter-professional Spine Assessment and Education Clinic (ISAEC) at the sub-region level
- Implement the Levels of Care Framework
- Continue to expand Self-Directed Care
- Support the provincial Opioid Strategy with a local Opioid Services Strategy with sub-regional focus
- Expand access to psychotherapy services at the sub-region level
- Continue to implement the Supportive Housing Strategy.

Drive Quality and Value

As a primary funder of health care services, the LHIN must support the sustainability of health system partner organizations in a constrained funding environment. Health care decisions must be evidenced-based and reflect the patient experience. The Central West LHIN is committed to funding and using health care resources in a sustainable, effective and efficient way that demonstrates quality and value to the community. This is realized through ongoing provincial processes designed to ensure accountability and transparency, development of the Central West LHIN PFAC, working with HQO on the implementation of quality standards, and local level planning and support for quality.

2018/19 Planned Activities

- Refresh the balanced scorecard and develop a performance management framework
- Engage the Central West LHIN PFAC to support health planning
- Measure and report on patient experience and confidence measures
- Advance priorities identified in the 2018/19 Central West LHIN Integrated Quality Plan
- Advance the priorities identified in the 2018/19 Central West LHIN Home and Community Care QIP
- Support the implementation of relevant HQO quality standards at the sub-region level.

Connect and Inform

The Central West LHIN is committed to improving population health and reducing disparities through inclusive, evidence-based and coordinated actions across the continuum of care. In support of the *Patients First Act*, the LHIN is working with public health, community and health system partners to launch health promotion strategies that connect, inform and support better population health outcomes across its sub-regions. These partnerships have resulted in the development of the Healthy Communities initiative, a Health Equity Charter, and population level data analysis at the sub-region level.

2018/19 Planned Activities

- Champion the Central West LHIN Health Equity Charter across health and social service organizations
- Complete sub-region health equity impact assessments for all initiatives
- Leverage the Central West LHIN and Public Health Steering Committee to assess local population health needs and promote innovative and collaborative solutions
- Develop sub-region community data profiles to support evidence-informed decision making at the local level
- Expand and scale the multi-sectoral neighborhood-based Healthy Communities initiative.

Demonstrate System Leadership

The Central West LHIN is responsible for ensuring that the local health system delivers the best possible outcomes in terms of population health, the patient experience and value. To carry out these responsibilities, the Central West LHIN works with health system partners to provide system leadership that includes capacity planning, guiding system-wide initiatives, and supporting stakeholders to provide the best possible care and outcomes for patients. Direction and support is provided to HSPs, SPOs and community partners on provincial priorities that increasingly call for collaboration with other levels of government, across LHIN boundaries, and beyond the health sector.

2018/19 Planned Activities

- Improve patient flow across acute care and home and community care settings
- Strengthen the LTC home sector in partnership with the Ministry of Health and Long-Term Care (MOHLTC)
- Advance health care for patients, practitioners and providers through digital innovation.



Build Integrated Networks of Care

PRIORITY DESCRIPTION

The LHIN remains committed to ensuring residents have access to high-quality, patient-centred care. This requires better integration into strong networks of care, investing in areas that require additional capacity, and looking for new and innovative ways to deliver care. It will be accomplished by enhancing continuity of care within and between primary care, Health Links, services for seniors, mental health and addictions, palliative care, and home and community care. Much of this work will be achieved through the LHIN's commitment to planning and delivering high-quality networks of care at a sub-region level.

Primary Care

Increase timely access to primary care, including inter-professional care teams, and enable seamless transitions between primary care and social services at the sub-region level.

Government Priorities

Ontario's [*Patients First: Action Plan for Health Care*](#) (*Patients First*) and Minister Mandate Letter identify timely access to primary care and improved transitions among providers, as key components toward ensuring the needs of patients remain central to the health care system. Accordingly, the Central West LHIN is developing a plan that focuses on assessing primary care capacity at the sub-region level, improving access to inter-professional health care providers and facilitating effective, seamless transitions between primary care and supporting health services.

Current Status

The Central West LHIN continues to work with family health teams (FHTs), community health centres (CHCs) and primary care providers (PCPs) practicing in other models of organized care, to ensure residents have timely access to multi-disciplinary primary care, provided in appropriate settings and as close to home as possible.

Approximately 592⁴⁶ family physicians provide care throughout the Central West LHIN. 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.

A high number of residents in the Central West LHIN are attached to a primary care physician. Ninety-five per cent of adult residents reported having had a regular family doctor in 2016/17⁴⁷. However, while most residents reported having had a family doctor, only 53 per cent reported that they could see their primary care provider on the same or next day when sick⁴⁸.

The three emergency departments (EDs) in the Central West LHIN have smaller proportions of low acuity visits compared to the province on the whole (Canadian Triage and Acuity Scale (CTAS) IV/V: 18 per cent vs. 31 per cent)⁴⁹ and the lowest rate of ED visits among the 14 LHINs for conditions that could be treated in alternative primary care settings (4.1 per 1,000 population aged one to 74 years in 2016-17⁵⁰). This suggests that Central West LHIN residents are not turning to local EDs for conditions that would be best managed within the community.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Complete a sub-region Primary Care Capacity Assessment Key activities: – Receive, analyze and synthesize critical primary care data from the Ministry of Health and Long-Term Care (MOHLTC) – Develop an assessment of primary care capacity at sub-region and LHIN levels	Complete	March 31, 2019

⁴⁶ Health Analytics Branch, MOHLTC, July 2017

⁴⁷ Health Care Experience Survey (April 2016 to March 2017)

⁴⁸ Health Care Experience Survey (April 2016 to March 2017)

⁴⁹ ER Analytics Fiscal Year End Report, Access to Care, Cancer Care Ontario

⁵⁰ Ministry-LHIN Stocktake Report, FY2016

- Develop a plan for each sub-region to address service gaps and improve access to medically appropriate care.		
Action Plan 2: Improve transitions in care through sub-region initiatives Key activities: - Implement sub-region collaborative work plan initiatives attached to the transitions in care sub-region priority area - Expand the scope, scale and spread of the Health Links approach to care across the sub-regions and LHIN - Work with specialty care providers to support transitions using enabling technologies.	Complete	March 31, 2020
Action Plan 3 : Increase access to interprofessional care teams Key activities: - Implement the first phase of a multi-phase plan to expand inter-professional care teams across four identified sub-regions - Evaluate performance of “phase one” implementation strategy - Plan for “phase two” expansion of inter-professional care teams across all sub-regions.	In Progress	March 31, 2020

Specialist Care

Increase medically appropriate and timely access, consistency and integration of specialist care.

Government Priorities

Improving medically appropriate access to specialist care, in particular musculoskeletal (MSK) conditions, is a key priority of *Patients First* and Minister Mandate Letter, and is well aligned with the Access to Specialists and Specialty Care Strategy.

The goal for local level implementation of the provincial MSK Strategy is to develop a system that provides timely, appropriate and transparent specialist care in Ontario. The MOHLTC is taking a step towards achieving this vision by enabling the scaled expansion and integration of proven MSK service delivery models. While successful models and other incentives for high quality MSK care

currently exist, aligning with and implementing these strategies more broadly across the LHIN is critical to achieving integration with the continuum of care.

Current Status

In the Central West LHIN, two acute care organizations – William Osler Health System (Osler) and Headwaters Health Care Centre (Headwaters) – operate screening clinics for arthritis. In addition, Osler also offers a screening and assessment clinic for select orthopedic conditions. The Osler clinics are staffed by an orthopedic surgeon and an advanced practice physiotherapist, while the Headwaters arthritis clinic is staffed by an Advanced Practice Physiotherapist. Both clinics offer patients non-surgical treatment if they do not need surgical intervention.

Over 8,000 inpatient and outpatient MSK cases are completed in the Central West LHIN by Osler each year of which, over 70 per cent are carried out on patients who reside in the LHIN. Over 3,000 of these cases are hip and knee replacement procedures that will now be processed through the Centralized Intake and Assessment Centre (CIAC) as part of first phase of the MSK Strategy.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Expansion of the Centralized Intake and Assessment Centre (CIAC) Key activities: – Continue implementation and uptake of the CIAC for hip and knee surgeries – Monitor and evaluate program results – Plan for expansion of the CIAC, as it relates to new clinical pathways.	In Progress	March 31, 2020
Action Plan 2: Implementation of Interprofessional Spine Assessment and Education Clinics (ISAEC) Key activities: – Identify key sites and partners to implement the ISAEC model for lower back pain at the sub-region level – Develop communication and change management plans to support implementation of the ISAEC model	Complete	March 31, 2019

– Monitor and evaluate program results.		
Action Plan 3 : Support uptake of enabling technologies Key activities: – Develop plan to enhance adoption of enabling technologies among specialists (e.g. eReferral) – Implement communication and change management plans to encourage adoption – Monitor and evaluate program results.	Complete	March 31, 2019

Mental Health and Addictions

Improve access to community mental health services, social housing, and psychotherapy at the sub-region level.

Government Priorities

Mental health and addictions initiatives currently underway or being explored by the Central West LHIN align with *Patients First*, the Minister Mandate Letter, provincial Opioid Strategy, [Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy](#), and the [Moving on Mental Health](#) action plan for supporting children and youth with mental health needs.

The LHIN remains committed to ensuring timely access to the most appropriate services as close to home as possible, with improvements being made through targeted efforts to access mental health and addictions services at the sub-region level, implementation of the Opioid Strategy, and expanding access to psychotherapy and supportive housing across the region.

Current Status

The Central West LHIN funds seven mental health and addictions organizations, including six community-based providers and an acute care facility operating two sites with inpatient units and community programs. Mental health and addictions services provided in the Central West LHIN range in function, intensity and duration to offer a broad range of health and social supports.

In 2016/17 these organizations collectively delivered services to over 24,600 unique individuals, and an additional 14,000 people received support from other sources such as peer/self-help programs and crisis services. Given the variability along the continuum of care, people who access these services receive an average of three to 76 visits. Just over 74 per cent of unique participants in 56 per cent of the programs receive fewer than 10 visits annually. The most broadly used mental health and addictions service is supportive housing, which serves just over 1,600 people and has an equal number waiting to access this service.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Increase mental health and addictions supports and access at a sub-region level Key activities: - Engage and secure commitment of key partners - Identify needs and local resources by sub-region - Develop and implement the community mental health and addictions electronic pathway in the system access model (SAM) - Identify walk-in support locations in each sub-region.	In Progress	March 31, 2020
Action Plan 2: Continue development of a local Opioid Services Strategy Key activities: - Use the provincial Opioid Strategy as the basis for a local opioid services strategy - Align opioids services strategy with local public health units - Plan and execute expansion of addictions services in alignment with local opioid services strategy.	In Progress	March 31, 2020
Action Plan 3 : Expand sub-region access to psychotherapy services Key activities: - Identify psychotherapy service needs at the sub-region level - Work with sub-region partners to develop a local psychotherapy services plan per the MOHLTC multi-year directive and ensure alignment with the population health needs in each sub-region - Monitor and expand structured psychotherapy through inter-professional teams in each sub-region.	In Progress	March 31, 2020



Action Plan 4 : Implement the Supportive Housing Strategy Key activities: – Lead local implementation of the MOHLTC multi-year supportive housing investment strategy – Work with local planning and housing partners to increase availability of supportive housing stock – Monitor quarterly implementation of the supportive housing strategy expansion.	In Progress	March 31, 2020
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Dementia Care

Increase support for individuals living with dementia, and their care partners, so they can live well at home and have a better quality of life.

Government Priorities

The Central West LHIN's work to advance dementia care is well aligned with *Patients First* and the Minister Mandate Letter. Specifically, the Central West LHIN will work with the MOHLTC to lead local implementation of the provincial Dementia Strategy, and execute the regional dementia capacity plan to better support individuals living with dementia, and their caregivers, so they can age in place for as long as possible.

Current Status

The Central West LHIN is committed to supporting people living with dementia, and their caregivers through a variety of ways.

Each of the nine LHIN-funded adult day programs, one exclusively, have participants who live with dementia.

Respite care is an important part of caring for people living with dementia and their families. In 2016/17, Central West LHIN Home and Community Care provided in-home respite services to 34751 people, many of whom are living with dementia. In addition, people living with dementia are frequently cared for in eight LHIN-funded Long-Term Care (LTC) home respite beds.

A LHIN-funded Behavioural Supports Ontario (BSO) Champion provides support at all 23 LTC homes in the LHIN. The LHIN also funds two community-based Nurses, two Neuro-behavioural Nurse Practitioners, and five Psychogeriatric Consultants (PRC) to assist LTC homes and community agencies in the delivery of care to people suffering from responsive behaviours, many of which are the result of dementia.

⁵¹ Client Health and Related Information System, data retrieved August 2017

Two Behaviour Support Transition Nurses assist people living with dementia, their caregivers and health professionals to move patients from one level of care to another. The BSO program in the Central West LHIN received additional funding in 2016/17 and 2017/18 to expand existing services and to increase the annual training offered to health care professionals in the area of responsive behaviours. In 2016/17, LTC-based BSO programs in the Central West LHIN supported 978 people with responsive behaviours. The BSO program also supported 363 people living in the community along with 875 of their family members and caregivers.

Building capacity through education and professional development remains a priority for the BSO program. In 2016/17, 464 education and training events were delivered to 11,312 participants.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Develop a Regional Dementia Strategy Key activities: – Utilize the Dementia Capacity Planning framework, complete a needs assessment at the sub-region and LHIN level – Develop a Regional Dementia Strategy with a focus on: ○ Support people with dementia ○ Support care partners ○ Develop local workforce ○ Raise public awareness ○ Implement strategy at sub-region level to address service gaps and improve access to appropriate care and services for patients living with dementia.	Complete	March 31, 2019

Palliative Care

Increase integration, access and continuity in care settings for end-of-life and palliative patients and their caregivers.

Government Priorities

The [2016 Palliative and End-of-Life Care Provincial Roundtable Report](#) outlined key themes to improve palliative and end-of-care in Ontario. Locally, the Central West LHIN's palliative care portfolio has identified key actions that will be undertaken to address the key findings of this report.



The LHIN has further honed its palliative and end-of-life care portfolio to align with the four priority areas identified in the [Ontario Palliative Care Network Action Plan](#). More specifically, the Central West LHIN Palliative Care Network (CWPCN) is working to ensure residents in this region are serviced by a health system that has:

- Earlier and more equitable access to end-of-life and palliative care services
- Increased access to home-based palliative care
- Enhanced connections across settings and providers
- Improved patient and caregiver experiences by aligning with patient goals.

Current Status

In 2016/17 Central West LHIN Home and Community Care delivered services to approximately 2,000 palliative patients. Moving forward, with a growing and aging population, palliative care needs will increase, requiring improved care planning and communication between patients, caregivers and providers to manage symptoms and avoid unnecessary visits to the ED.

With a vision to provide *exemplary hospice palliative care for all*, the CWPCN has remained focused on advancing palliative and end-of-life care across the region.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Increase communication and the provision of care Key activities: – Align testing of care delivery models with sub-region collaborative work plans, as appropriate – Support the adoption of the Health Links philosophy, including testing and use of coordinated care plans for patients with palliative care needs.	In Progress	March 31, 2020
Action Plan 2: Develop strategies to increase early identification of palliative care needs Key activities: – Expand early identification in primary and acute settings – Development and/or adoption of patient- and family-facing tools to support early identification of palliative care needs	In Progress	March 31, 2020

- Build public awareness of early identification and palliative care.		
Action Plan 3: Enhance culturally appropriate caregiver supports Key activities: - Work with caregivers to identify education and resource needs to support them in their role - Develop resources and supports for culturally sensitive care by working with caregivers.	In Progress	March 31, 2020
Action Plan 4: Strengthen palliative care approach in Long-Term Care (LTC) Homes Key activities: - Work with residents, caregivers and staff to identify palliative care related needs in LTC homes - Collaborate with LTC home administrators to develop a palliative approach that is reflective of the needs of residents.	In Progress	March 31, 2020
Action Plan 5: Strengthen supports for end-of-life needs, including Medical Assistance In Dying (MAID) and residential hospices Key activities: - Work with patients, caregivers, families, clinicians and other health system partners to identify gaps and barriers in the provision of end-of-life needs - Develop an action plan to address policy, process and programming gaps in current system.	In Progress	March 31, 2020



Drive Quality and Value

PRIORITY DESCRIPTION

The Central West LHIN is committed to continuously improving the health status of residents by strengthening its accountability and service delivery. This can only be accomplished through effective partnerships with Health Service Providers (HSPs), community partners, Service Provider Organizations (SPOs) and other stakeholders where collaboration on local and provincial quality-focused and evidence-informed initiatives are aligned. Accordingly, the Central West LHIN is focused on using health care resources in a sustainable, effective and efficient way that demonstrates quality and value to the community while protecting the public health care system now and for future generations.

Transparency and Accountability

Ensure the Central West LHIN funds and delivers health care resources in a sustainable, effective manner.

Government Priorities

A key priority for *Patients First* is the need to ensure Ontario's health care system is both sustainable and transparent. Accordingly, the Central West LHIN is accountable for local health system outcomes, and is committed to monitoring and managing the performance expectations and targets and set and achieved by its funded partners.

Current Status

Central West LHIN performance outcomes are reflected in a balanced scorecard, which monitors the status of indicators that track health system priorities established by the MOHLTC as well as local priorities outlined in IHSP 2016/19 IHSP. Through accountability agreements, which are monitored and managed regularly and reported to the Board of Directors, the Central West LHIN also oversees a set of performance expectations established for each of its funded HSPs.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Refresh balanced scorecard and develop performance management framework Key activities: – Engage key providers in mapping the strategy required to achieve established LHIN performance expectations – Identify suitable and appropriate indicators to monitor LHIN-wide performance – Develop and implement a revised Central West LHIN balanced scorecard that reflects: ○ Central West LHIN accountabilities under the <i>Patients First Act</i> ○ Inclusion of home and community care ○ Creation of LHIN sub-regions ○ Inclusion of primary care – Develop and implement a Central West LHIN performance management framework that reflects the LHIN's new structure and ensures performance expectations of the organization, and its service providers, are monitored and managed.	Complete	March 31, 2019

Quality Improvement

Ensure the Central West LHIN consistently delivers safe, effective patient-centred care in an equitable, timely and efficient manner.

Government Priorities

Quality initiatives are helping to protect the public health care system through evidence-based decisions about value and quality that create an environment for sustainability and wise use of resources.

Current State

The Central West LHIN Regional Quality Table was established in 2016, serving as an enabler to support the quality agenda. It has since been realigned with Sub-region Collaboratives to ensure support for quality improvement priorities.



Building quality improvement capacity and capability through initiatives such as provincial Improving & Driving Excellence Across Sectors (IDEAS) cohorts, is a key driver to support the quality improvement work taking place across the LHIN.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Implement a three-year Integrated Quality Plan Key activities: – Supported by the Central West LHIN Board of Directors Quality Committee, Regional Quality Table, Home and Community Care Integrated Quality Council, and the Health System Partners Quality Leaders Forum begin implementation of a 2018-2021 Integrated Quality Plan – Build quality improvement capacity across Central West LHIN health partners – Support uptake of HQO quality standards.	In Progress	March 31, 2021
Action Plan 2: Develop a 2018/19 Central West LHIN Home and Community Care Quality Improvement Plan (QIP) Key activities: – Draft the 2018/19 Central West LHIN Home and Community Care QIP – Submit the QIP to HQO and post on the Central West LHIN website by April 1, 2018 – Deploy the QIP throughout the 2018/19 fiscal year.	Complete	March 31, 2019

Action Plan 3: Maintain current Health Standards Organization and Accreditation Canada “Accredited with Exemplary Standing” status Key activities: – Work with Health Standards Organization and Accreditation Canada to meet the designated requirements to maintain Accredited with Exemplary Standing status – Develop and implement a plan to maintain Accreditation status.	In progress	June 2019
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Patient Experience

Improve the patient and caregiver experience by focusing on transitions in care, engagement and support.

Government Priorities

Enhancing the patient experience is a major deliverable in achieving a high-quality, high performing and value-driven health care system. Aligned with the objectives of *Patients First*, the Central West LHIN is committed to continuously improving the local health care system in such a manner that makes it more responsive to patients, easier to navigate and focused on improved quality outcomes. This can only be achieved through leveraging the knowledge of patients, families and informal caregivers in planning and decision-making at the system level. These valuable perspectives ensure that care plans will be appropriate and more effective in improving patient outcomes.

Measuring patient experience across the Central West LHIN will help to identify and remove gaps in care. In addition, sharing selected metrics among health service providers helps align improvement efforts and the ongoing enhancement of the patient experience.

Current State

The Central West LHIN has remained committed to enhancing the patient experience through the appointment of a Patient and Family Advisory Committee (PFAC). In 2017/18, aligned with the LHIN’s sub-region geographies, PFAC members were recruited in a manner that effectively represents the LHIN’s patient and caregiver populations. Members of the PFAC are now integrated across a number of LHIN committees and tables, providing an opportunity for them to inform discussions and decisions about our local health system and patient care.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Support the Central West LHIN Patient and Family Advisory Committee (PFAC) Key activities: – Create a 2018/19 work plan that is aligned with the Integrated Quality Plan – Integrate PFAC members into sub-region collaboratives – Incorporate the voice and perspectives of patients, families and caregivers to create a health care system that is truly patient-centred and focused on meeting the needs of the population it serves.	In Progress	March 31, 2021
Action Plan 2: Measure patient experience and confidence Key activities: – Complete a robust environmental scan to confirm evidence-informed patient experience and confidence metrics are in alignment with the system – Identify key processes to integrate and operationalize metrics while working with health system partners – Align patient experience and confidence metrics with accountability processes.	In Progress	March 31, 2021

Connect and Inform



PRIORITY DESCRIPTION

At the core of the Central West LHIN's Vision is a commitment to improving population health and reducing disparities through inclusive, evidence-based and coordinated actions across the continuum of care. In support of Ontario's *Patients First Act*, the LHIN is working with public health, community and health

system partners to launch health promotion strategies that connect, inform and support better population health outcomes across its sub-regions.

Healthy Communities

Enhance evidence-informed decision making to support population health planning at a sub-region level.

Government Priorities

To better meet the needs of residents at risk of poor health outcomes, the LHIN will enhance collaboration between the health care system and other organizations focused on population health.

Addressing health equity is also a critical factor in creating a sustainable health system, reducing the incidence of costly, preventable illnesses and related treatments.

In addition to Ontario's *Patients First Act*, LHIN initiatives in this area also align with recommendations from the MOHLTC Public Health Workstream Report published in November 2017.

Current State

The Central West LHIN is actively partnering with public health, community and health system partners to create supportive environments, promoting informed decisions that enable healthier choices and better use of the overall health care system.

As a first step, the LHIN and health system partners must understand local context, health disparities and service needs. To this end, the LHIN is assessing current service delivery and future planning needs to create healthier environments, improve access and enhance the quality of health care services. This population-based approach is a cornerstone of sub-region planning.

To further identify key disparities, barriers and priorities, the LHIN has also begun to cross-reference health care utilization data with socio-demographic and health status information at the sub-region level.

An emerging opportunity is the LHIN-led Healthy Communities Initiative, which mobilizes the community in an effort to reduce the risk of health concerns and chronic illness by empowering residents to make healthier eating decisions and active lifestyle changes. In response to high diabetes prevalence rates, unhealthy environments and a population with a high genetic predisposition to diabetes, the Healthy Communities Initiative is enabling cross-sector partnerships between Public Health Units, primary care providers, school administrators and other stakeholders.



Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Complete sub-region community data profile and population health assessments Key activities: – Work with public health units, local and regional municipalities, health service partners and the MOHLTC to collect and analyze data – Develop and refine community data profiles at the sub-region level – Begin to explore data collection and analysis at the neighbourhood level within sub-regions.	Complete	March 31, 2019
Action Plan 2: Leverage enhanced collaboration of the Central West LHIN/Public Health Steering Committee Key activities: – Determine strategy, objectives and outcomes for collaborative efforts to support local health planning and service delivery decision making – Develop and approve a work plan shared between the LHIN and the participating public health units – Identify resources to support/implement the strategy and work plan – Identify additional structural supports (e.g. working groups) and partners needed to achieve objectives and outcomes.	In progress	Ongoing

Action Plan 3: Implement the Healthy Communities Initiative Key activities: - The LHIN will work with Peel Public Health, William Osler Health System, the City of Brampton and community partners across Brampton to advance the Healthy Communities Initiative - Deliver multi-pronged strategies across a number of settings to create supportive environments for healthy living - Implement setting-appropriate and evidence-informed health promotion initiatives across school, workplaces, places of worship and community centres, in priority areas.	In progress	March 31, 2021
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Equity

Promote health equity considerations with a focus on addressing health disparities at a sub-region level.

Government Priorities

Outlined in the Federal [Charter of Rights and Freedoms](#), [Canada Health Act](#), and Ontario's [Commitment to the Future of Medicare Act \(2004\)](#), [Human Rights Code](#) and [Patients First Act](#), the MOHLTC and LHINs have a legal and ethical responsibility to integrate equity considerations into the planning and decision making process.

Highlighted in the Minister Mandate Letter, the LHIN will enhance its focus on the need to promote equity and recognize the impact of the social determinants of health to effectively reduce disparities and inequities in the planning, design, delivery and evaluation of health services.

Current State

The Central West LHIN has evolved its approach to health equity, engaging with health service providers and pan-LHIN stakeholders in working toward the improvement of equitable access to care and minimization of barriers for vulnerable populations. More specifically:

- Evolution of the LHIN's Diversity and Health Equity Core Action Group (CAG)
- Production of the Central West LHIN Health Equity Symposium
- Implementation and review of Health Equity Progress Reports
- Piloting of equity based data at time of intake



■ Development of a Health Equity Charter.

Development of a Health Equity Charter reflects a shared commitment to improve health equity across the Central West LHIN and a shared commitment to action by the LHIN and funded partners. Using a review of best practices and in consultation with multiple stakeholders, the Charter acknowledges that achieving equity is a gradual process, requiring continued reflection, combined efforts and collaboration. As a living document, the Charter will be used to ensure equity planning reflects the evolution of the Central West LHIN's landscape and health care needs of its diverse residents.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Adopt Central West LHIN Health Equity Charter Key activities: – Work with health system partners to increase an awareness of health disparities across the system and general population – Work with health system partners to implement the Central West LHIN Health Equity Charter – Develop action plans to ensure charter principles are actioned across organizations in the LHIN.	Complete	March 31, 2019
Action Plan 2: Apply health equity impact assessments for sub-region planning Key activities: – Work with health system partners to increase an awareness of health disparities across the system and general population – Work with health system partners to implement the Central West LHIN Health Equity Charter – Develop action plans to ensure charter principles are actioned across organizations in the LHIN.	Complete	September 30, 2019



Demonstrate System Leadership

PRIORITY DESCRIPTION

The Central West LHIN is responsible for ensuring that the health system delivers the best possible outcomes in terms of population health, value and the patient experience. The Central West LHIN works with its partners to provide system leadership that includes capacity planning, guiding system-wide initiatives and supporting stakeholders to provide the best possible care and outcomes for the population. This leadership also takes place in the context of provincial priorities that increasingly call for collaboration with government and other entities that extend well beyond the health sector.

Hospitals and Partners

Improve patient flow across acute care and home and community care settings.

Government Priorities

Aligned with Ontario's *Patients First Act* and Minister Mandate Letter, the Central West LHIN will continue to focus on the efficient flow of patients from acute care to home and community care settings. Ensuring patients have access to high quality emergency, acute, and post-acute care remains a consistent priority for Ontario's health care system, and is articulated through [Ontario's Wait Time Strategy](#) and [Excellent Care for All Act \(2010\)](#).

From a broader health system perspective, the Central West LHIN also balances the needs and pressures of acute care facilities within the context of comprehensive community capacity planning. This is to ensure that system level pressures are effectively and efficiently addressed so patients receive the right care, at the right time, and in the right time – whether in hospital or the community. The Central West LHIN remains committed the effective and efficient use of services in the EDs and acute care facilities across the region.

Current State

Hospitals in the Central West LHIN continue to face pressures associated with growing ED volumes and high acuity of patients, and are working in close partnership with the LHIN's Home and Community Care programs and other community providers to optimize patient flow. This is evidenced in the data.

In 2016/17, there were a total of 266,466 ED visits to Central West LHIN hospitals⁵², an increase of 28 per cent over 2010/11. Brampton Civic Hospital had

⁵² ER Fiscal Year Report September 2017 – Cancer Care Ontario

the busiest ED in Ontario in 2016/17 with eight per cent more visits than the next busiest ED⁵³. 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.

Hospitals in the Central West LHIN had one of the shortest average provincial acute and total length of stay results in 2016/17⁵⁴, where average length of stay for alternate level of care (ALC) was 12 days – the second shortest in the province. The Central West LHIN also had the lowest ALC rate (inpatient capacity lost to ALC) of all 14 LHINs.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Encourage development of innovative patient flow initiatives Key activities: – Monitor and analyze ED and in-patient data to identify trends impacting admissions and length of stay – Work with hospitals across the region to deploy local strategies that improve patient flow, decrease hospital admissions and reduce ALC – Support home and community care patients to avoid preventable readmissions to the ED through palliative care, mental health and other home and community care supports.	Complete	March 31, 2019

⁵³ ER Fiscal Year Report September 2017 – Cancer Care Ontario

⁵⁴ IntelliHealth DAD (accessed 2017-12-06)

Action Plan 2: Support continuity of care and effective discharge planning Key activities: – Work with hospitals, community partners and service providers to better integrate home and community care services that facilitate expedient discharge planning and avoid readmissions.	Complete	March 31, 2019
Action Plan 3: Enhance Long-Term Care (LTC) home patient supports and continuity of care Key activities: – Work with hospitals and LTC homes to facilitate relationships and initiatives to prevent avoidable ED visits – Work with nurse practitioners across LTC homes in the LHIN to develop and implement effective strategies to support continuity of care for LTC home residents when admitted to acute care facilities.	Complete	September 30, 2018

Long-Term Care

In partnership with the MOHLTC, strengthen the LTC home sector.

Government Priorities

In alignment with the Minister Mandate Letter and in collaboration with the LTC home sector, the Central West LHIN is committed to strengthening the sector, ensuring services and supports are in place to respond to the needs of a rapidly aging population.

Through [Aging with Confidence: Ontario's Action Plan for Seniors](#), the government has articulated a 20-point plan to bolster services for the province's senior population. In an effort to reduce wait lists, this plan includes 5,000 new LTC beds by 2021/22, and a pledge to increase capacity by adding 30,000 new beds over the next decade. The Central West LHIN will continue to work with the MOHLTC to ensure appropriate capacity is allocated in this region.

Current State

The Central West LHIN provides funding to 23 LTC homes across the region. In 2016/17, average occupancy in Central West LHIN LTC homes was 99.5 per cent, very similar to the provincial average of 99.1 per cent. Compared to the provincial average of 3 years, the average length of stay in Central West LTC homes is 3.4 years.



With a rapidly growing and aging population that will see the seniors population grow by 62 per cent by 2025, the Central West LHIN anticipates an increasing demand for LTC beds and community-based services and supports for seniors to age in place.

In 2014, the MOHLTC announced the [Enhanced Long-Term Care Home Renewal Strategy](#) that supports eligible LTC Home operators to redevelop 30,000 of the province's older LTC beds, structurally classified as "B", "C" and "upgraded D" under the first phase of the LTC Home Renewal Strategy. The Central West LHIN has been working closely to support the redevelopment of all eligible LTC homes in its jurisdiction including Kipling Acres in Etobicoke, redeveloped with capital funding made available through this process. The second phase of its redevelopment was completed in May 2017, bringing all remaining 145 beds (of 337 beds) into service. This redeveloped facility now meets all modern LTC design standards, provides greater wheelchair access for residents in private and public spaces, and the community hub includes an adult day program, early learning & child care centre and senior centre.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Continue to advance LTC home renewal initiatives Key activities: – Support the redevelopment of all eligible LTC homes in the Central West LHIN – Continue to develop and implement a Central West PACE-like program (Program for Advanced Care for the Elderly) – 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	September 2020
Action Plan 2: Complete a LTC home capacity assessment Key Activities: – Work with hospitals, community partners and service providers to further integrate home and community care services that facilitate expedient discharge planning and avoid readmissions.	Complete	March 31, 2019

Action Plan 3: Plan for new LTC home licenses Key activities: – Identify emerging needs for beds in the region by building on the capacity assessment of LTC homes in the Central West LHIN – Work with the MOHLTC to determine appropriate license allocation to the LHIN – Work with relevant partners across the LHIN to develop a plan that optimizes current and future capital opportunities for effective bed allocation.	In progress	March 31, 2021
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Digital Health

Advance health care for patients, practitioners and providers through digital innovation.

Government Priorities

The *Patients First: Digital Health Strategy* and 2018/19 provincial digital health priorities provide vital supports to the *Patients First: Action Plan for Health Care*. Information technology (IT) and information management (IM) are key elements that help to empower patients and connect health care providers in their circle of care. In support of a seamless patient experience, digital health solutions enable patients, their caregivers and their health service providers to share information, and coordinate services quickly and efficiently at each transition point.

Current State

Digital health solutions enable authorized health care providers to quickly access shared health information in their efforts to make informed care decisions. Digital health solutions also enable health care providers to see a patient's complete record, regardless of how many different providers a patient is seeing.

In support of health system transformation, the MOHLTC, along with system partners, is using digital health as a platform for delivering care to those who need it the most. Aligned to Ontario's *Patients First: Action Plan for Health Care*, the provincial Digital Health Strategy is focused on advancing modern, integrated patient-centred care to strengthen quality, effectiveness and accountability while stimulating innovation and growth in the digital health sector.

The Central West LHIN Enabling Technologies for Integration Digital Health Plan identifies specific priority initiatives each fiscal year.



Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Implement eVisit solution Key activities: – Work with sub-region Clinical Leads to promote the uptake of eVisit initiatives among primary care providers and patients.	In progress	March 31, 2020
Action Plan 2: Implement eReferral solution Key activities: – Work with centralized intake and assessment partners to implement an eReferral solution – Work with sub-region collaboratives to increase the uptake of eReferral for complex patients (HealthLinks).	In progress	March 31, 2020
Action Plan 3: Implement eConsult solution Key activities: – Work with sub-region Clinical Leads to promote the uptake of eConsult initiatives among primary care providers and specialists.	In progress	March 31, 2020



Section 3 – Home and Community Care



Build Integrated Networks of Care

PRIORITY DESCRIPTION

The Central West Local Health Integration Network (LHIN) remains committed to ensuring residents have access to high-quality, patient-centred care. This requires better integration into strong networks of care, investing in areas that require additional capacity, and looking for new and innovative ways to deliver care. This will be accomplished by enhancing continuity of care both within and between primary care, health links, services for seniors, mental health and addictions, palliative care, and home and community care. Much of this work will be achieved through the LHIN's commitment to planning and delivering high quality networks of care at a sub-region level.

Care Coordination

Improve the coordination and consistency of home and community care services at points of transition.

Government Priorities

Central West LHIN Home and Community Care (HCC) services is focused on strengthening relationships with service provider partners to ensure care coordination practices are efficient, effective and meet the needs of our diverse



and rapidly changing population. Such services focus on delivering patient-centred home care that is responsive, collaborative, transparent and flexible.

Aligned with *Patients First* and the Minister Mandate Letter, there is a need to deliver better coordinated service and integrated care in the community, closer to home through:

- Continued transformation of home and community care
- Improved working conditions for personal support workers (PSW)
- Enhanced palliative care in the home and in community settings
- Additional access to rehabilitation services for seniors.

Current State

In 2016/17, home and community care services in the Central West LHIN were provided to more than 42,000 patients. Of the residents who received in home services, 57 per cent were “long-stay” patients who received care for more than 90 days and 38 per cent received two or more services (excluding care coordination). In home nursing services were provided to nearly 11,000 residents, with an average of 24 visits per person.

The LHIN continues to make strides in this area by implementing best practices in the delivery of home and community care. In support of LHIN sub-regions, care coordination services are aligned by sub-region through our optimized neighbourhood care coordination model, allowing for greater opportunities to address the local health care needs of the communities across the region. In addition, patient caseloads and care coordinators are aligned and assigned to every primary care practitioner in the Central West LHIN.

To ensure better integrated services for pediatric patients, the Central West LHIN has been working closely with the Complex Kids Clinic of Ontario to support an improved coordinated care model for children with complex medical needs.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Modernize care coordination Key activities: – Conduct an in-depth review of patient experience data – Review and adopt best practices in care coordination – Implement the interRAI-HC tool – Complete an in-depth review of service planning guidelines and patient assessment data as a result of interRAI-HC tool.	Complete	March 31, 2019

Action Plan 2: Enhance care coordination for specialized populations Key activities: - Develop the ideal care coordination model for seniors and rehabilitation population health needs - Refine model of care coordination for the pediatric population.	Complete	September 2018.
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Primary Care

Strengthen the connection between care coordination and primary care

Government Priorities

Patients First and the Minister Mandate Letter identify timely access to primary care and improved care transitions as key priorities. The Central West LHIN is continues to expand Health Links and the development of coordinated care plans while encouraging the uptake of enabling technologies such as Telemedicine.

Current State

The Central West LHIN continues to work with Family Health Teams (FHTs), Community Health Centres (CHCs) and primary care practitioners in other models of organized care to ensure residents have timely access to multi-disciplinary primary care, provided in appropriate settings and as close to home as possible.

Each primary care provider in the Central West LHIN is aligned with one care coordinator who is responsible for reviewing patient care plans, participating in rounds, problem-solving on complex health care needs and providing updates in-service interventions in the home.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Strengthen connections between primary care and care coordination Key activities: - Continue to augment and refine care coordination and primary care data at the sub-region level by building on the 2017/18 current state assessment	Complete	March 31, 2019



- Complete a health equity impact assessment to identify diverse communities within LHIN sub-regions, and determine care coordination requirements to meet their needs - Continue to engage patients, family members and caregivers, health care providers, primary care organizations and other partners to refine the “co-designed” models that work for communities within each sub-region - Work with inter-professional care teams across the LHIN to define the level of integration care coordinators in primary care provide within their respective communities - Evaluate the strengths and opportunities of primary care and home and community care linkages, followed by an approach to evaluate broader linkages with care coordination - Work with the MOHLTC and other partners to implement a pan-LHIN evaluation framework to assess the effectiveness of the implementation model.		
Action Plan 2: Expand Health Links and coordinated care planning Key activities: - Work with sub-region partners to develop and implement targeted strategies to increase the development of coordinated care plans for complex patients - Work with sub-region Clinical Lead to encourage primary care providers to complete coordinated care plans for complex patients - Monitor and assess the quality and utilization of coordinated care plans by partners and agencies across the sub-regions.	Complete	March 31, 2019

– Increase opportunities to collaborate and share care planning information in real time by leveraging access to CHRIS for primary care and Health Links team members.		
Action Plan 3: Promote the uptake of Telemedicine in primary care settings Key activities: – Use Telemedicine to engage primary care and facilitate touchpoints between primary care providers and patients.	In progress	March 31, 2020



Drive Quality and Value

PRIORITY DESCRIPTION

The Central West LHIN is committed to continuously improving the health and health status of residents by strengthening its own accountability and service delivery. This can only be accomplished through effective partnerships with Health Service Providers (HSPs) and other stakeholders, where collaboration on local and provincial quality-focused and evidence-informed initiatives are aligned. Accordingly, the LHIN is focused on using health care resources in a sustainable, effective and efficient way that demonstrates quality and value to the community while protecting the public health care system now and for future generations.

Quality Improvements

Ensure the consistent delivery of safe, effective, patient-centred care in an equitable, timely and efficient manner.

Government Priorities

Home and community care programs and services delivered in the Central West LHIN will continue to be informed by experts, rooted in evidence and use standardized tools and supports to strengthen the quality of services and programs.

Current State

Central West LHIN Home and Community Care places the quality and value of service delivery at the forefront of its priorities.

As outlined by Health Quality Ontario (HQP), Quality Improvement Plans (QIPs) highlight the importance of setting quality improvement goals to ultimately improve service delivery in the home care sector. Accordingly, the Central West LHIN's 2017/18 QIP focused on falls prevention, hospital readmissions, early interventions in palliative care, and improvements in patient experience.

Central West LHIN Home and Community Care will continue to offer self-directed care options that enable patients and their caregivers the autonomy - with support from the Central West LHIN - to obtain professional personal support or homemaking services from providers of their choice. As an early adopter of the self-directed model of care, the Central West LHIN is already supporting patients and caregivers in coordinating their own care, and will work to expand and align the program to the provincial Self-Directed Care Organization by 2019.

The provincial Levels of Care initiative ensures that services and assessments are equitable and consistent across the Ontario. Assessments for services are focused on addressing the functional needs of patients as well as environmental factors that will influence the level of personal support services a patient will receive.

The Central West Wound Care Program is focused on improving outcomes through the introduction of evidence-based treatment protocols catered to different wound types and maximizes the use of cross-sector partnerships and system wide resources. Since implementation, wound care documentation has increased to 82 per cent, the average length of stay decreased by 22 per cent, hospital readmissions were significantly reduced and the average wound age for all patients decreased from 41 weeks to 12 weeks.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Implement the Levels of Care Framework Key activities: – Conduct and assessment of existing practices – Redesign service guidelines in alignment with levels of care.	Complete	March 31, 2019
Action Plan 2: Continue to expand Self-Directed Care Key activities: – Support patients in their homes to manage their own care.	Complete	March 31, 2019

Action Plan 3: Continue to implement Wound Care best practices Key activities: – Build on the success of the existing Wound Care Program while implementing three new HQO wound care standards consistently across the Central West LHIN.	In-Progress	Ongoing
Action Plan 4: Explore Innovative models of home and community care delivery Key activities: – Assess opportunities to create delivery partnership models for appropriate home and community care populations across LHIN sub-regions.	In Progress	March 31, 2020



Demonstrate System Leadership

PRIORITY DESCRIPTION

The Central West LHIN is responsible for ensuring that the health system delivers the best possible outcomes in terms of population health, value and the patient experience. The LHIN works with its partners to provide system leadership that includes capacity planning, guiding system-wide initiatives and supporting stakeholders to provide the best possible care and outcomes for the population. This leadership also takes place in the context of provincial priorities that increasingly call for collaboration with government and other entities that extend well beyond the health sector.

Hospitals and Partners

Improve patient flow across acute care and home and community care settings.

Government Priorities

Aligned with Ontario's *Patients First Act* and Minister Mandate Letter, the Central West LHIN will continue to focus on the efficient flow of patients from acute care to home and community care settings. Ensuring patients have access to high quality emergency, acute and post-acute care has been a consistent priority for



the provincial health care system, articulated through [Ontario's Wait Time Strategy](#) and [Excellent Care for All Act](#).

From a broader health system perspective, the LHIN balances the needs and pressures of acute care facilities within the context of comprehensive community capacity planning. This ensures that system level pressures are effectively and efficiently addressed, and that patients receive the right care, at the right time, and in the right place.

Current State

Over the past year, the Central West LHIN has continued to successfully implement and scale one of six programs using the provincial bundled funding model. Hospital to Home (H2H) is a joint collaboration between the Central West LHIN, Headwaters Health Care Centre (Headwaters), William Osler Health System (Osler) and the Ontario Telemedicine Network (OTN). This innovative model of care is helping improve clinical handoffs and information-sharing when patients leave hospital.

The program employs direct care nurses in the delivery of in-home care to patients who need additional post-discharge support. Since launch in 2015, H2H has helped reduce the average length of stay for admitted patients by 52.7 percent, decreased hospital readmissions by seven per cent and ED visits by seven and a half per cent.

In addition to H2H, the Central West LHIN, in collaboration with Osler, has developed an Integrated Cross-Continuum Stroke Rehabilitation Model to address system access challenges for patients navigating the health system following a stroke. An integrated team of specialists from both organizations has been working to minimize access and flow challenges related to rehabilitation patients.

Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Implement bundled care for rehabilitation services Key activities: – Plan and implement an expanded Integrated Stroke Rehab program – Plan and implement the Hips and Knees bundled care services.	Complete	March 31, 2019

Action Plan 2: Support innovative models of care coordination at hospital transition points Key activities: – Evaluate and leverage the Integrated Care Coordinator models within Central West LHIN hospitals – Establish coordination models that match population and stakeholder needs in order to strengthen integrated care at transition points.	Complete	March 31, 2019
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Digital Health

Advance health care for patients, practitioners and providers through digital innovation.

Government Priorities

Digital health solutions enable authorized health care providers to quickly access shared health information in their efforts to make informed care decisions. Digital health solutions also enable health care providers to see a patient's complete record, regardless of how many different providers a patient is seeing.

In support of health system transformation, the MOHLTC, along with system partners, is using digital health as a platform for delivering care to those who need it the most. Aligned to Ontario's *Patients First: Action Plan for Health Care*, the provincial Digital Health Strategy is focused on advancing modern, integrated patient-centred care to strengthen quality, effectiveness and accountability while stimulating innovation and growth in the digital health sector.

The Central West LHIN Enabling Technologies for Integration Digital Health Plan identifies specific priority initiatives each fiscal year.

Current State

Over the past two years, the LHIN has worked closely with OTN to increase the use of video conferencing with patients across the region. This initiative is designed to help care coordinators and physicians increase their interactions between high-risk, high-complexity patients by removing barriers associated with distance and mobility through the use of technology.

By increasing the frequency of patient/care provider contact for this group, potential complications can be identified earlier, reducing system impact and improving patient outcomes.



Action Plans/Interventions

	Expected Status (March 31, 2019)	Expected Completion Date
Action Plan 1: Advance uptake of Telehomecare program across sub-regions Key activities: – Plan and implement an expanded Integrated Stroke Rehab program – Plan and implement the Hips and Knees bundled care services.	In-Progress	Ongoing
Action Plan 2: Implement eShift digital solution Key activities: – Review current service guidelines for eShift – Implement supporting technologies to enable service delivery for pediatric and palliative patients.	Complete	March 31, 2019



Section 4 – French Language Services and Indigenous Peoples

FRENCH LANGUAGE SERVICES

The Central West LHIN includes a vibrant community of over 14,000 francophone residents looking for better access to health care services in French. Working with Reflet Salvéo, the LHIN is able to better understand the needs of the francophone community and collaborate with health service partners to ensure their needs are met.

Throughout 2017/18, the Central West LHIN worked with local health care system partners, including Reflet Salvéo, to develop a French Language Services (FLS) Joint Action Plan (Action Plan) which identified the following key priorities:

- Increase active offer of French Language Services
- Enhance the mental health status of Francophone newcomers
- Promote equity
- Support the integration of Francophone perspectives in health system planning activities.

The Joint Action Plan speaks to a need to account for how the LHIN, in accordance with the [French Language Services Act](#), will assume responsibility for the provision of home and community care services available in French. Beginning with a thorough analysis of the process for coordination of French-language home and community care services, the LHIN and its partners are committed to acting on subsequent recommendations for improvement to ensure the provision of Active Offer.

In order to deliver on the Action Plan priority of increasing Active Offer, the LHIN has been working to increase FLS capacity of HSPs, supporting them through training on Active Offer and assessing the supply and demand of French Language speaking Health Human Resources at a sub-region level.



In November 2017, in collaboration with Reflet Salvéo and William Osler Health System, the LHIN organized a Francophone *“Open Forum and Community Dinner”*. This engagement event helped identify Francophone healthcare priorities that could be integrated into local health system transformation strategies.

Francophone engagement opportunities in 2018/19 will focus on:

- Engaging Francophone communities through community needs assessment initiatives i.e. surveys, community consultations, to collect data and information on the French-speaking populations' experience within the health system to support LHIN planning and decision-making
- Organizing community engagement activities related to system transformation and/or service planning initiatives within priority health sectors
- Promoting Francophone participation in patient experience sharing initiatives i.e. Patient and Family Advisory Committee (PFAC)
- Engaging Francophone residents, including immigrants and new comers, to raise awareness surrounding challenges in accessing FLS
- Building relationships with community leaders and agencies serving the Francophone community to improve equity and accessibility to FLS
- Engaging Francophone seniors, to identify their needs and develop strategies to improve their access to a wider range of home and community services adapted to their linguistic and cultural needs
- Raising awareness and use of available FLS within LHIN priority areas i.e. Mental Health and Addictions (MH&A), Home and Community Care (HCC), Primary Care, etc.

Building on the 2017/18 readiness assessments, the LHIN will continue to work with partners to help prioritize actions and create a roadmap to designation (full or partial). The LHIN will also continue to evaluate the annual FLS reports of its partners, as required by their Service Accountability Agreements (SAAs), integrating FLS performance indicators into new SAAs or when revisiting existing ones. Accordingly, key activities in 2018/19 will focus on:

- Assessing and evaluating the FLS capacity of all LHIN-funded partners, developing plans that help them build their FLS capacity and strengthen health services in French
- Identifying additional health system partners that can offer FLS within local LHIN communities
- Engaging agencies that serve Francophone immigrants, refugees, ethno-cultural and racialized (IRER) populations, as well as Francophone residents themselves, to raise awareness surrounding the stigma associated with Mental Health and Addictions and provide assist with respect to system navigation/access
- Supporting, where appropriate, the development of home and community care service initiatives toward Francophone seniors, in response to their unique needs and challenges identified through Francophone community engagement
- Providing ongoing support to partners within the North Etobicoke-Malton-West Woodbridge Sub-Region with respect to further enhancing Francophone service offerings

- Supporting, as resources are available and in collaboration with Reflet Salvéo, the development of Primary Care services in French.

INDIGENOUS PEOPLES

The Central West LHIN is committed to engaging Indigenous communities to ensure the local health care system understands and is responsive to their unique needs.

As part of the Provincial Indigenous Leads Network (PILN), the LHIN is equally committed to addressing a range of health care topics that impact Indigenous people from constructs of wellness to mental health, chronic disease management and palliative care. This includes working with local health system partners – Peel Aboriginal Network (PAN), Dufferin County Cultural Resource Circle (DCCRC), Credit River Metis Council (CRMC) – to ensure Indigenous residents receive culturally competent care that recognizes and is tailored to a group's particular social, cultural and linguistic needs. Designed to ensure better health and healthier outcomes, this work aligns local health care programs and services with existing regional, provincial and federal health planning, health programming and service delivery systems.

In 2017/18 the LHIN participated in various Indigenous engagements including CRMC meetings, a Métis Planting Garden, PAN project planning, a DCCRC Needs Assessment and the DCCRC Annual General Meeting. The LHIN also worked in collaboration with PAN, CRMC and the Mississauga Halton LHIN to develop an Indigenous Advisory Health Circle (IAHC), which aims to provide guidance and advice to both LHINs in the planning, implementation, and evaluation of culturally based, culturally secure, health programs and services for Indigenous communities.

A key outcome of these engagements is the implementation of the 2018/19 Indigenous Holistic Health and Wellness project, a cost-sharing initiative with the Central West and Mississauga Halton LHINs and Ministry of Health and Long-Term Care (MOHLTC). Funding will be provided to the Canadian Mental Health Association (CMHA) Peel Dufferin Branch to hire Indigenous Elders and Métis Senators at PAN and CRMC. These human resources will help build capacity for culturally appropriate direct care/services, and provide on-site mentorship, relationship and capacity building opportunities to support cultural safety across health service providers. As a result, PAN and CRMC will also be able to increase the number of their traditional ceremonies and community events led by Elders, Métis Senators, and Knowledge Keepers, whereby families and individuals will have the ability to register for traditional indigenous ceremonies.

While the LHIN continues to ensure Indigenous peoples are included in local health system planning, 2018/19 funding will support existing partnerships with Indigenous organizations. This includes the Indigenous Diabetes Health Circle whose culturally tailored wellness services include diabetic foot clinics and nutritious Eating workshops.

Non-Indigenous HSPs in both LHINs will also participate in Indigenous Cultural Safety Training - workshops, e-learning modules and an educational forum "Advancing Indigenous Health" - to raise awareness about how behaviours and



actions impact on the delivery of care; in particular, with respect to indigenous people.

The LHINs will support Indigenous patients in moving easily through the healthcare system in a culturally safe and relevant manner by:

- Providing resource support and advocacy for Indigenous patients, caregivers, and their families to improve patient pathways and transition points within the hospital and hospital to community care and may include culturally and spiritually relevant care (where requested)
- Assisting in bridging the service gaps between Indigenous communities and health care providers
- Facilitating linkages to services that may include (but are not limited to) mental health and addictions, chronic disease management, primary care and acute care
- Assisting with the coordination and include the provision of care between health care providers (hospital, home care, health and social service organizations) and Indigenous service providers or community based health services
- Enabling case input and guidance on case management practices, promotion of culturally appropriate health care services, and quality improvement processes all relative and specific to Indigenous patients.

Key deliverables related to system navigation include:

- Provide non-Indigenous partners with an “Educational Forum” on “Advancing Indigenous Health and Wellness” hosting Indigenous Elders/Leaders
- Organize “Roots of Tolerance” workshops for Central West LHIN HSPs
- Provide health care partners within the LHIN with dedicated face-to-face cultural competency learning opportunities to increase their understanding of Indigenous cultures, history, traditions and lived experience
- Provide Indigenous individuals with Diabetic Foot Clinics and Nutritious Eating Workshop
- Increase Indigenous access to traditional ceremonies and healing services provided by Elders, such as Sweat Lodge ceremonies, Talking and Healing circles.

The LHIN will also continue to support local health system partners in their want to complete the Indigenous Cultural Safety training program. To date, over 150 staff from partner organizations have completed the training.

Through ongoing implementation of Patients First, and in collaboration with key Indigenous Leaders/Elders and stakeholders, the Central West LHIN will be able to:

- Build stronger relationships with members of Indigenous communities, in collaboration with Mississauga Halton LHIN, to guide future engagement activities between the LHIN and Indigenous peoples
- Gain a better understanding of Indigenous peoples, programs and gaps in Indigenous health services
- Engage Indigenous organizations and communities to ensure their voices are included in health care planning across the continuum of care.



Section 5 – Performance Measures

Ontario's Local Health Integration Network's (LHINs) are mandated to plan, fund, and integrate local health care systems, and to plan and deliver home and community care services. An important part of this mandate is to ensure that effective measures are in place to track, monitor and report on the success of its activities. The Central West LHIN's performance focuses on both provincial and local health care system priorities.

BUILD INTEGRATED NETWORKS OF CARE

Goal	Performance Measure(s)
Primary Care – Increase timely access to primary care, including inter-professional care teams, and seamless transitions between primary care and social services at the sub-region level – Improve integration and transitions between primary care and home and community care at the sub-region level.	– Increase the number of complex patients with a coordinated care plan by 10 per cent within each sub-region.

Goal	Performance Measure(s)
Care Coordination: – Improve coordination and consistency of home and community care services at transitions.	– Decrease the 90th percentile wait time from community for home care services by five per cent, or amount needed to meet provincial target of 21 days. – Decrease the 90th percentile wait time from hospital for home care services by five per cent, or amount needed to meet provincial target.
Specialist Care – Increase medically appropriate and timely access, consistency, and integration of specialist care.	– Increase the percentage of priority 2, 3 and 4 hip replacements completed within access targets by five per cent. – Increase the percentage of priority 2, 3 and 4 knee replacements completed within access targets by five per cent. – Increase the number of Central West LHIN primary care physicians accessing specialist consults through eConsult by 25 per cent, from 100 to 125 (approximately 5 per sub region). – Increase the number of Central West LHIN specialists responding to eConsult requests by 75 per cent, from 20 to 35.
Mental Health and Addictions: – Increase access to community mental health services, social housing, and psychotherapy at the sub-region level – Improve integration of Mental Health and Addictions supports and services in a home and community care setting.	– Decrease repeat unscheduled emergency visits within 30 days for mental health conditions by five per cent – Decrease repeat unscheduled emergency visits within 30 days for substance use conditions by five per cent.

Goal	Performance Measure(s)
Dementia Care – Increase support for individuals living with dementia, and their care partners, so they can live well at home and have a better quality of life.	– Increase the number of coordinated care plans for patients living with complex care needs by 38 per cent.
Palliative Care – Increase integration, access and continuity in care settings for end-of-life and palliative patients and their caregivers.	– Decrease the percentage of decedents who die in hospital.

DRIVE QUALITY AND VALUE

Goal	Performance Measure(s)
Transparency and Accountability – Ensure the Central West LHIN funds and delivers health care resources in a sustainable, effective manner.	– Percentage of community-based Health Service Providers who achieve 90 per cent or more of their annual service volume targets will improve to 90 percent.
Quality Improvements – Ensure the Central West LHIN consistently delivers safe, effective patient-centred care in an equitable, timely and efficient manner.	– Implementation of one HQO quality standards at the sub-region level.
Patient Experience – Improve patient and caregiver experience by focus on transitions in care, engagement and support.	– All complaints are acknowledged upon receipt. – Complaints are responded to within three business days of receipt.* <i>*Where the process requires more than 48 hours, communication will be made to keep the complainant informed of ongoing efforts to appropriately refer and/or resolve the matter.</i>



CONNECT AND INFORM

Goal	Performance Measure(s)
Healthy Communities Enhance evidence-informed decision making to support population health planning at a sub-region level.	Increase number of health promoting environmental and policy changes made amongst partner agencies involved in the Healthy Communities initiative to 25.
Equity Promote health equity considerations with a focus on addressing health disparities at a sub-region level.	Increase application of Health Equity Impact Assessments on initiatives at the sub-region level to 100 per cent.

DEMONSTRATE SYSTEM LEADERSHIP

Goal	Performance Measure(s)
Hospitals and Partners Improve patient flow across acute care and home and community care settings.	- Maintain Central West LHIN ALC rate. - Decrease the 90th percentile wait time from hospital for home care services by five per cent or amount needed to meet provincial target.
Long Term Care Strengthen the LTC home sector in partnership with the MOHLTC.	Reduce ED transfers from LTC homes by five per cent.

Digital Health – Advance health care for our patients, practitioners and providers through digital innovation.	– Increase the number of Central West LHIN primary care physicians accessing patients through eVisit from the pilot of phase of 6 to 100, targeting approximately 20 physicians per sub-region. – Increase the number of Central West LHIN primary care physicians accessing specialist consults through eConsult by 25 per cent, from 100 to 125 (approximately 5 per sub region). – Increase the number of Central West LHIN specialists responding to eConsult requests by 75 per cent, from 20 to 35. – Increase uptake of Telehomecare, by five percent, from 550 to 578.
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Section 6 – Risks and Mitigation Plans

Risk/Barrier	Mitigation Plan(s)
Complexity of the relationship between provincial primary care associations and provincial health care planning influences local partnerships.	- The Central West LHIN will continue to work with the Ministry of Health and Long-Term Care (MOHLTC), member-based organizations such as the Ontario Medical Association (OMA) and Ontario College of Family Physicians (OCFP), and sub-region Clinical Leads to support local physician advocacy of programs and service enhancements. - Based on the readiness of primary care leadership and a collective commitment to physician collaboration and co-designed outcomes, the Central West LHIN undertake a managed implementation plan for renewal.

Year-over-year population growth will enhance structural deficits related to physician supply, increasing pressure on the availability of and access to local family physicians for residents.	- Enhance the use and monitoring of 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.
Year-over-year population growth will enhance structural deficits related to the demand for home and community care. This could produce gaps in service and dedication of care coordinator resources to primary care partners.	- Leverage sub-region planning to determine priority setting of developmental supports required in strengthening the consistency and quality of partnered relationships between primary care and care coordination functions. - Develop an in depth analysis of care coordination resources across the LHIN.
By 2025, the population of seniors in the Central West LHIN is projected to grow by 62% per cent. Caring for this growing population in the community will continue to be a challenge as acuity levels rise.	- The Central West LHIN must continue to expand and improve the quality of community-based services for seniors and their caregivers through ongoing funding support and integration opportunities.
Lack of provider support for consistent adoption and implementation of quality standards, results in ongoing variations in care delivery.	- Link the adoption of quality standards to accountability agreements. - Regular reporting and monitoring of implementation status.

Misalignment of local and provincial approaches to measuring and monitoring patient experience.	– Consultation with the MOHLTC and Health Quality Ontario (HQP) to ensure alignment and avoiding duplication of efforts.
Competing local and provincial priorities may impede the LHIN's ability to make progress on its action plans.	– Work with the senior LHIN leadership team to effectively prioritize local and provincial priorities, by effectively scoping action plans while remaining mindful of provincial priorities.
Service and resource pressures, driven by population growth, may deflect attention away from the specific needs of high-risk communities.	Integrate the health equity lens in sub-region planning to ensure health disparities are identified and appropriately addressed.



Section 7 – LHIN Operations

Three-Year LHIN Spending Plan

	2017/18 Estimated Actuals	2018/19 Allocation	2019/20 Planned Expenses	2020/21 Planned Expenses
Allocation: Home Care/LHIN Delivered Services¹				
Salaries (Worked hours + Benefit hours cost)	19,314,116.00	20,114,020.00	20,114,020.00	20,114,020.00
Benefit Contributions	4,608,628.00	4,688,136.00	4,688,136.00	4,688,136.00
Med/Surgical Supplies & Drugs	7,305,808.00	7,299,923.00	7,299,923.00	7,299,923.00
Supplies & Sundry Expenses	1,184,355.00	1,192,535.00	1,192,535.00	1,192,535.00
Equipment Expenses		38,850.00	38,850.00	38,850.00
Amortization on Major Equip, Software License & Fees	30,356.00	11,479.00	11,479.00	11,479.00
Contracted Out Expense	93,334,287.00	89,553,571.00	89,553,571.00	89,553,571.00
Buildings & Grounds Expenses				
Building Amortization				
TOTAL: Home Care/LHIN Delivered Services	125,777,550.00	122,898,514.00	122,898,514.00	122,898,514.00
Allocation: Aggregated Operation of the LHIN²				
Salaries (Worked hours + Benefit hours cost)	2,360,773	2,364,111	2,313,714	2,263,318
Benefit Contributions	497,906	498,750	488,167	477,583
Med/Surgical Supplies & Drugs				
Supplies & Sundry Expenses	377,316	483,075	480,539	480,468
Equipment Expenses		5,000	5,000	5,000
Amortization on Major Equip, Software License & Fees				
Contracted Out Expense				
Buildings & Grounds Expenses				
Building Amortization				
Sub-total: LHIN Operations	3,235,995	3,350,936	3,287,420	3,226,369
Sub-total: LHIN Operations Initiatives	824,692	788,500	788,500	788,500
Sub-total: LHIN Operations Digital Health	3,060,000		-	-
TOTAL: Aggregated Operation of the LHIN²	7,120,687	4,139,436	4,075,920	4,014,869
Allocation: Integrated LHIN Administration/ Governance³				
Salaries (Worked hours + Benefit hours cost)	6,079,053	6,223,148	6,223,148	6,223,148
Benefit Contributions	1,157,681	1,277,293	1,277,293	1,277,293
Med/Surgical Supplies & Drugs				
Supplies & Sundry Expenses	1,684,867	1,386,369	1,386,369	1,386,369
Equipment Expenses	312,838	481,704	481,704	481,704
Amortization on Major Equip, Software License & Fees				
Contracted Out Expense				
Buildings & Grounds Expenses	1,578,962	1,683,971	1,683,971	1,683,971
Building Amortization	287,492	162,514	162,514	162,514
TOTAL: Integrated LHIN Administration/ Governance	11,100,893	11,214,999	11,214,999	11,214,999
TOTAL: LHIN SPENDING PLAN	143,999,130	138,252,949	138,189,433	138,128,382



Spending Plan Notes:

1. Home Care/LHIN Delivered Services envelope includes direct services as defined in Schedule 7, Table 1 of the 2015-18 Ministry LHIN Accountability Agreement.
2. Aggregated Operation of the LHIN includes:
 - i. LHIN Operations: The LHIN's mandated system operations and activities related to planning, funding and integrating.
 - ii. LHIN Operations Initiatives: Activities that are one-time and/or require separate reporting per MOHLTC funding letters. (e.g. French Language Services and Indigenous engagement).
 - iii. LHIN Operations Digital Health: The coordinated and integrated use of electronic systems, information and communication technologies to facilitate the collection, exchange and management of personal health information in order to improve the quality, access, productivity and sustainability of the health care system.
3. Integrated LHIN Administration/Governance envelope includes indirect costs such as administration and overhead expenses of the combined organization.

Three-Year LHIN Staffing Plan (Full-Time Equivalents or FTE¹)

	2017/18 Actuals as of February 28/2018	2018/19 Forecast	2019/20 Forecast	2020/21 Forecast
Home Care/LHIN Delivered Services²				
Management and Operational Support (MOS)	60.42	64.23	64.23	64.23
Unit Producing Personnel (UPP) FTE	191.84	190.95	190.95	190.95
Nurse Practitioner (NP) FTE	4.06	5.00	5.00	5.00
Physician FTE				
Total Home Care/LHIN Delivered Services FTE	256.32	260.18	260.18	260.18
LHIN Operations³				
MOS FTE	14.38	14.80	14.30	13.80
UPP FTE	9.31	9.50	9.50	9.50
NP FTE	0.19	0.00	0.00	0.00
Physician FTE	0.62	0.40	0.40	0.40
Total LHIN Operations FTE	24.50	24.70	24.20	23.70
LHIN Operations Initiatives⁴				
MOS FTE	2.13	0.00	0.00	0.00
UPP FTE	1.10	1.00	1.00	1.00
NP FTE				
Physician FTE	0.95	1.80	1.80	1.80
Total LHIN Operations Initiatives FTE	4.18	2.80	2.80	2.80
LHIN Operations Digital Health⁵				
MOS FTE	3.25	0.00	0.00	0.00
UPP FTE				
NP FTE				
Physician FTE				
Total LHIN Operations Digital Health FTE	3.25	0.00	0.00	0.00
Integrated LHIN Administration/ Governance⁶				
MOS FTE	28.21	25.90	25.90	25.90
UPP FTE	38.27	40.40	40.40	40.40
NP FTE				
Physician FTE				
Total FTE	66.48	66.30	66.30	66.30
TOTAL FTE SUMMARY	354.73	353.98	353.48	352.98

Staffing Plan Notes:

1. One Full Time Equivalent equals 1950 hours per year. One FTE may be comprised of multiple staff.
2. Home Care/LHIN Delivered Services envelope includes direct services as defined in Schedule 7, Table 1 of the 2015-18 Ministry LHIN Accountability Agreement.
3. LHIN Operations includes the LHIN's mandated system operations/activities related to planning, funding and integrating.
4. LHIN Operations includes activities that are one-time and/or require separate reporting as per MOHLTC funding letters. (e.g. French Language Services and Indigenous engagement).
5. LHIN Operations Digital Health includes the coordinated and integrated use of electronic systems, information and communication technologies to facilitate the collection, exchange and management of personal health information in order to improve the quality, access, productivity and sustainability of the health care system.
6. Integrated LHIN Administration/Governance envelope includes indirect costs such as administration and overhead expenses of the combined organization.



Section 8 - Communications & Community Engagement

Through Ontario's [Patients First: Action Plan for Health Care](#), the [Patients First Act](#) and Minister Mandate Letter the Central West LHIN has a critical role to play in moving provincial and local priorities forward. In 2018/19, there must be balance between transformational work while ensuring the continuity of current LHIN operations. The ongoing and further evolution of sub-regions will be a key communications opportunity for the Central West LHIN. Care communities will be advanced by working closely with partners – including patients – to co-design a more integrated care delivery model.

■ Business Objectives

In 2018/19, the Central West LHIN will continue to work in partnership with patients, families, the Ministry of Health and Long-Term Care (MOHLTC), Health Service Providers (HSPs), Service Provider Organizations (SPOs), community partners and health care innovators to transform the local health care system based on current and future needs. Together, we will improve the patient experience, increase access to care and reduce wait times, while reducing health disparities. More specifically, the LHIN will work to:

- Deliver care that reflects the patient voice and is responsive to patients' needs, values and preferences
- Address the root causes of health inequities and the social determinants of health by investing in health promotion, and reducing the burden of disease and chronic illness
- Create healthy communities by improving access to primary care and reducing wait times for specialist care, mental health and addictions services, home and community care and acute care for patients when they need it
- Break down the silos between health care sectors and providers to ensure seamless transitions for patients

- Support innovation by delivering new models of care and digital solutions to make accessing care easier for patients and more efficient for health care providers.

In addition, while delivering on our mandate, we will ensure key pillars are maintained and strengthened:

- Promoting health equity, and reduce health disparities and inequities
- Respecting the diversity of LHIN communities, while promoting culturally safe care for Indigenous people and meeting the requirements of the French Language Services (FLS) Act
- Strengthening local engagement with Francophone and Indigenous communities
- Working with local partners to plan and deliver health services.

■ Communication Objectives

When taken in the context of Ontario's *Patients First*: Action Plan for Health Care, Minister Mandate Letter and LHIN 2016-2019 Integrated Health Service Plan (IHSP), a communications and community engagement strategy is essential to the successful realization of the many priorities and activities outlined in the LHIN's 2018/19 Annual Business Plan (ABP). More specifically, this communications and community engagement strategy will help to:

- Ensure the voices of patients and their families are captured and reflected in the implementation of initiatives
- Support the ongoing adoption of *Patients First* so that public confidence in the local health care system remains stable, patient care remains seamless and uninterrupted, and Central West LHIN residents are both informed and provided the opportunity to be actively involved in the work needed to strengthen the continuum of care
- Raise awareness of work related to system access, particularly with regard to home and community care and primary care, while forging stronger links these two sectors
- Build public confidence in the positive change taking place within their provincial and local health care systems
- Create awareness of LHIN sub-regions and how they will strengthen health care planning in the Central West LHIN
- Support the implementation of IHSP 2016-19 strategic priorities through ongoing communication and engagement with internal and external stakeholders who play pivotal roles in moving these priorities forward
- Promote LHIN investments in new programs and enhancements, helping people to navigate the system through an increased awareness of the health care options that are available to them
- Raise awareness of the Central West LHIN's role, its unique characteristics, value proposition, calibre and credibility of work, and importance within the local health care system
- Continue to build strong, trusted relationships with partner communications teams across the Central West LHIN, working together to optimize communication resources and coordinated services.



Francophone and Indigenous Communities

The Central West LHIN includes a vibrant francophone community that is looking for better access to health care services in French. The LHIN is committed to working with Reflet Salvéo to better understand and implement effective, targeted communication strategies and tactics to meaningfully engage the Francophone community.

The Central West LHIN's Indigenous communities also have unique needs including wellness, mental health, chronic disease management and palliative care. The LHIN is committed to engaging Indigenous communities to ensure their specific needs are understood and included in the planning process. The LHIN is equally committed to engaging with its partners in an effort to raise their awareness of and need to promote the delivery of culturally competent care.

■ Stakeholder Audiences

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

- Patients and Caregivers
- General Public
 - Residents
 - Community Organizations
- HSPs and SPO, 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 (Ontario Hospital Association (OHA), Ontario Nurses Association (ONA), Ontario Medical Association (OMA), etc.)
- Levels of Government
 - Municipal
 - Regional
 - Provincial including MOHLTC and other ministries as appropriate.
- Media.

■ Strategic Approach

- Develop communications that focus on the uniqueness of audiences in each care community, methods of communications for each audience and messages that will resonate targeted for specific audiences
- Raise awareness of system access and navigation for patients and families
- 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.

■ Community Engagement

In accordance with *Community Engagement Guidelines* (revised June 2016) and in keeping with the expectations of the *Local Health System Integration Act*

(LHSIA 2006), all LHINs undertake engagement to ensure the voices of the people served are reflected in decision-making. The objectives of Central West LHIN community engagement will be identified in advance and will vary across the following engagement continuum.

Inform and Educate: Provide accurate, timely, relevant and easy to understand information to the community about the LHIN and its operations, offering opportunities for community members to understand the problems, alternatives and/or solutions facing the local health care systems, and to gain a better understanding of the programs and services provided by the LHIN.

Gather Input: Obtain feedback on analysis and proposed changes, provides opportunities for LHIN communities to voice their opinions, express their concerns, and identify modifications that could improve the local health care system. Notably, engagement with the LHIN's Patient and Family Advisory Committee (PFAC) will be essential.

Consult: Seek out and receive the views of community stakeholders on policies, programs or services that affect them directly or in which they may have a significant interest, providing opportunities for dialogue between community and the LHIN.

Involve: Work directly with stakeholders to ensure their issues and concerns are consistently understood and considered, enabling residents and communities to raise their own issues. Community stakeholders may provide direct advice as this is a two-way communication process. Engagement with sub-region collaboratives and sub-regional Clinical Leads will be essential.

Collaborate: Work with and enable stakeholders to work through options and/or solutions to find common ground or agreement.

Empower: Delegated stakeholder decision making where final decision making authority, leading to action is assigned to a committee (ad hoc, standing) or other organized body (project-related work group or task).

■ Tactics

Patient/Caregiver Communications: To support the further awareness of services and supports available to patients and families, develop appropriate and relevant print and electronic collateral, tailored to population health and sub-region stakeholder groups/audiences.

Media: In an effort to reach a variety of audiences, the Central West LHIN will seek to maintain and build upon existing relationships with traditional and ethnic media, 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 feature stories to educate and inform communities regarding the current happenings and goings on the local health care system.

Digital: The Central West LHIN will look to enhance its presence with digital media by devoting time and resources to increase the use of social media platforms (Twitter, LinkedIn), establishing a formal social media policy, effectively



managing new and existing content, enhancing our websites, and committing to the development and use of video.

Newsletters: While the LHIN will continue to design and publish regular, targeted newsletters (external: LHINsights/internal: LHINsider) 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.

Publications: Develop corporate documents, including ABPs and Annual Reports, to highlight our alignment with our mandate and promote the work our teams do to support patients and families in the community.

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 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/Municipal Councils and MPPs: 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: The Central West LHIN will seek to increase awareness of the LHIN as a health care planning, funding, integration and delivery organization. As local residents experience their health care system through their local HSPs, 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

Provincial

Ontario is increasing access to care, reducing wait times and improving the patient experience through its *Patients First: Action Plan for Health Care* – protecting health care today and into the future.

Ontario's *Patients First: Action Plan for Health Care* sets clear and ambitious goals for the provincial health care system, placing patients at the centre by improving their health care experience: increasing access, connecting services, informing patients and protecting our health care system.

Changes underway supported by the Patients First have expanded the LHIN mandate and will give LHINs the tools, oversight and accountability they need to better integrate local health care services and coordinate care across the care continuum in a way that better serves patients.

- In May and June 2017, home care services and staff transferred from CCACs to LHINs. This was a structural system change that will help patients and their families get better access to a more local and integrated health care system. The process happened in carefully planned stages and was seamless for patients and home care clients. There was no disruption to care and providers remained the same.

Once fully implemented, these changes will make the health care system more responsive to local needs:

- Patients will benefit from improved access to primary care, including a single number to call when they need health information or advice on where to find a new family doctor or nurse practitioner.
- Primary care providers, inter-professional health care teams, hospitals, public health units and home and community care providers will be better able to communicate and share information, to ensure a smoother patient experience and transitions.
- Administration of the health care system will be streamlined and reduced, with savings put back into improving patient care.
- With PFACs in every LHIN, the voices of patients and families in their own health care planning will be strengthened.
- There will be an increased focus on cultural sensitivity and the delivery of health care services to Indigenous peoples and French speaking people in Ontario.

By putting patients first in everything we do, we will provide faster access to the care patients need today and make the necessary investments to ensure our health system will be there for patients for generations to come.

Local

Through IHSP 2016-2019, the Central West LHIN is increasing access to care, reducing wait times and improving the patient experience improving the health and healthy outcomes of patients and residents now and into the future.

IHSP 2016-2019 sets clear and ambitious goals for the local health care system, placing patients at the centre of their health care system by improving the health care experience: increasing access, connecting services, informing patients and protecting our health care system.

- 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 remains committed to building a more seamless and coordinated approach to patient care.
- 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.



By putting LHIN patients first, in everything we do, we will provide faster access to the care patients need today and make the necessary investments to ensure our local health system will be there for generations to come. Supported by the *Patients First Act*, the Central West LHIN has an expanded mandate with the tools, oversight and accountability needed to better integrate local health care services and coordinate care across the care continuum in a way that better serves local LHIN patients.

- In May 2017, home care services and staff transferred from the Central West CCAC to the Central West LHIN. This was a structural system change that will help LHIN patients and their families get better access to a more local and integrated health care system. The process happened in carefully planned stages and was seamless for local patients and home care clients. There was no disruption to care and providers remained the same.
- Through the Patients First, smaller geographic planning regions called sub-regions have been established within each LHIN to help LHINs to better understand and address patient needs at the local level.
- By looking at care patterns through a smaller lens, the Central West LHIN will be able to better identify and respond to community needs and work with local health system leaders, including family doctors, nurse practitioners, home care coordinators and home and community care service providers, to build more seamless local health care service delivery.

■ Evaluation

Identifying and tracking communication success factors enables the Central West LHIN to more effectively identify whether communication activities have been successful. A comprehensive evaluation of communications will be carried out using:

- Annual Community Consultation Study to assess public awareness of and satisfaction with their local health care system
- Annual Internal Communications Survey to assess the effectiveness of internal communications at the Central West LHIN
- Website traffic by tracking analytics
- Tone and volume of traditional media, online/social media and LHIN communication vehicles (emails, bulletins, etc.)
- Event participation and feedback
- Board member and senior leadership engagement and feedback on communications and community engagement activities
- Engagement of HSPs
- Feedback mechanisms and ongoing assessment tools to monitor the effectiveness of communication vehicles and messages.

BOARD OF DIRECTORS



Carmine Domanico
Chair
June 8/17 – June 7/20



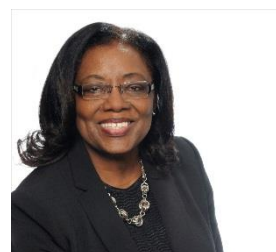
Jeff Payne
Vice Chair
May 27/15 - May 26/18



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



Neil Davis
Director
Nov. 28/16 – Nov. 27/19



Anita Gittens
Director
June 14/17 – June 13/20



Peter Harris
Director
Mar. 1/17 – Feb. 28/20



Ashish Kemkar
Director
Mar. 1/17 – Feb. 28/20



Dr. Hugh O'Brodovich
Director
May 31/17 – May 30/20



Heather Picken
Director
Jan. 8/18 – Jan. 7/21



Angélique Rebelo
Director
Nov 1/17 – Oct. 31/20



Moyra Vande Vooren
Director
Apr.12/17 – Apr. 11/20

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The Central West LHIN Annual Business Plan 2018/19 is available in both English and French.