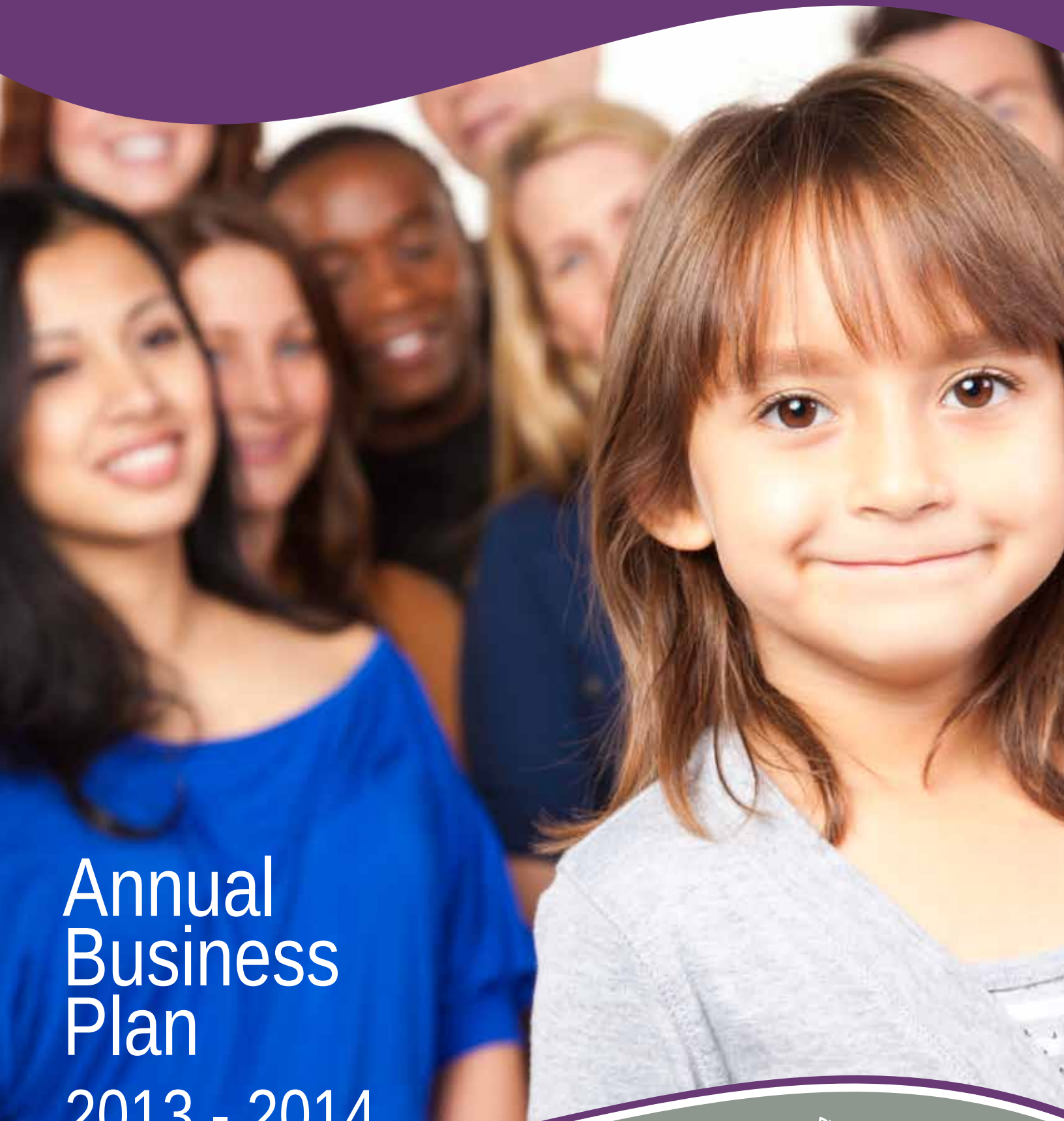
Waterloo Wellington **LHIN**



Annual Business Plan

2013 - 2014

Ontario

Waterloo Wellington Local Health Integration Network

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Waterloo Wellington Local Health Integration Network

The Waterloo Wellington Local Health Integration Network (WWLHIN) is responsible for planning, integrating and funding health services to improve the health and wellbeing of approximately 750,000 residents in Waterloo Region, Wellington County, the City of Guelph, and the southern part of Grey County.

Our Job as Leaders

The Waterloo Wellington Local Health Integration Network (WWLHIN) staff are experts on understanding the health needs of our community members and how they are impacted by the social determinants of health. In the WWLHIN office, our team of physicians, nurses and other professionals work hard to provide a resident-focused approach to healthcare investment, design and improvement.

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

Vision: Better Health – Better Futures

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

Ontario's Action Plan for Health Care

Better patient care through better value from our health care dollars

The initiatives that have been included in this Annual Business Plan are grounded in *Ontario's Action Plan for Health Care* as well as local health system planning and community engagement activities. They are designed to have the greatest impact on achieving the strategic priorities for local health care in Waterloo Wellington.

Ontario's Action Plan for Health Care is the plan to make Ontario the healthiest place in North America to grow up and grow old. It is a plan to strengthen the universal healthcare system and ensure it is there for your children and grandchildren.

In the Action Plan for Health Care, the Minister of Health outlined specific areas of focus for the health system in the coming years:

1. Support to become healthier including specific strategies around health promotion, promoting healthy habits and behaviours, supporting lifestyle changes and better management of chronic conditions.

2. Faster access and a stronger link to family health care including specific strategies such as strengthening the role of family health care, improving access to primary care, increasing the use of house calls to support care needs, incorporating Family Health Care into the Local Health Integration Networks, and driving a focus on quality and best practice.

3. The right care, at the right place, in the right time including specific strategies around timeliness and access, delivery of additional services in the community, integrated care processes, and a Seniors Health Strategy.

> Our plan is obsessively patient-centred. In tomorrow's health care system there is no room for self-interest, only the best interest of patients.*
>
> * *Ontario's Action Plan for Health Care*, 2012

Building the Plan

In building the Annual Business Plan, we reflected on our progress to date in implementing our strategy. Most recent updates on our strategy can be found in the attachments (appendix A and B). We have also completed an environmental scan of the health of our community during the development of the *Integrated Health Service Plan (IHSP 2013-2016)* which can be found at www.wwlhin.on.ca.

The specific initiatives within each of the local strategic priorities are guided by a set of corporate objectives and planning principles. These principles have been developed by speaking to our residents and performing web and phone surveys, gathering input from our Advisory Councils, working with local experts to review how our system is doing in general and in comparison with others, studying literature, and speaking with leaders from the best health systems in the world to understand what makes them successful and to assess what needs to happen here.

Corporate Objectives

Our corporate objectives identify how the Waterloo Wellington Local Health Integration Network will achieve the outcomes related to our local strategic priorities. They reflect how we will live out our mission, vision and values every day and how we will focus efforts to achieve positive outcomes for local residents. Our corporate objectives are:

- To provide transformational leadership to create a high-quality, integrated health system and collaborate with those who share this commitment.
- To commission quality health services in a sustainable health system.
- To integrate health services to achieve better health, better care and better value.
- To champion equity in population health and health outcomes.
- To attract and retain the best talent and create a great place to work.

Planning Principles

Our local planning principles have been developed based on both the principles outlined in *Ontario's Action Plan for Health Care*, and research on global best practice in achieving results in healthcare transformation. Together, we will use these principles when designing programs/services, pursuing integration opportunities and making investment decisions.

Principle #1: Start with the Triple Aim Objectives:

- Better Health: improve the health of the population and health equity
- Better Care: enhance the experience of care (including quality, access, and reliability)
- Better Value: reduce, or at least control, the per capita cost of care

Principle #2: Focus on the top 1-10% of health care users who utilize most of the healthcare resources – people with complex health and social care need

Principle #3: Identify opportunities to shift capacity to primary and community care

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

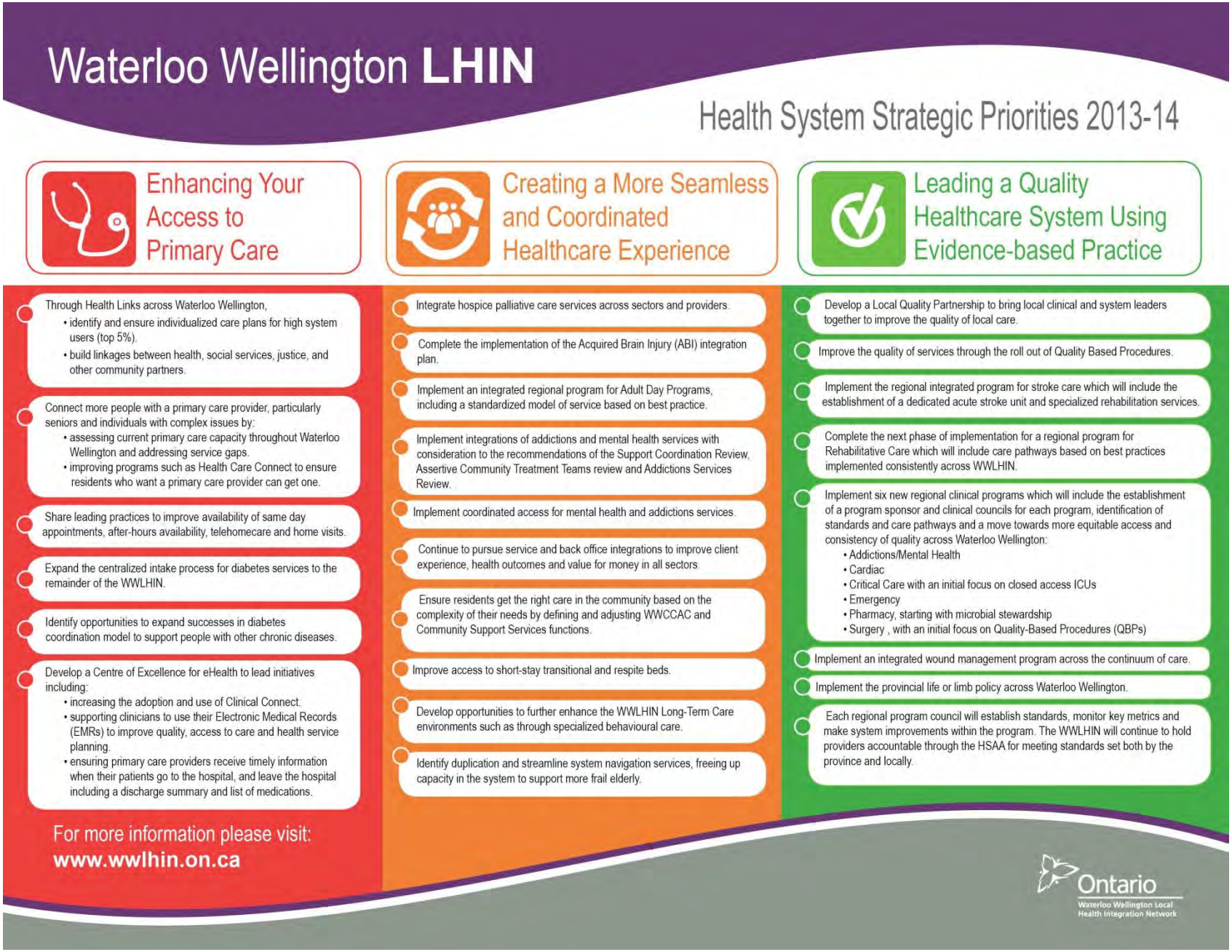
We take great care in listening to our residents in order to determine the necessary changes and improvements for our local healthcare system, and to ensure those changes match the needs of our community. During the development of the *Local Integrated Health Service Plan (IHSP 2013-2016)* we heard from residents and providers and reviewed our local data. We analyzed results from surveys, community engagement sessions, reports and an environmental scan of our area. These enhanced our understanding of the health of our population, how our residents rate their experience with the local healthcare system, what services our residents are currently using, and how our community is accessing care services.

While we have had many successes in improving our local health care system, there is still much more work to do. Through our review process several key areas have been identified that need to improve to ensure better health and better care for our residents and create better value for taxpayer dollars.

We Must Accelerate System **CHANGE**

The local plan for healthcare services in Waterloo Wellington is an ambitious one. It is driven by the need to do things differently and to create something extraordinary. Our local health system is transforming from a series of fragmented programs/services into a truly integrated system of care, a system that is centred on our residents' needs, rather than organizations. Our residents' health and wellbeing must be placed as the top priority within our system redesign. Together, with our health service providers, we will ensure that the provincial vision for improved healthcare is translated at the local level in a way that is meaningful to and resonates with our residents.

Strategic Priorities for our Local Healthcare System


Waterloo Wellington LHIN
Health System Strategic Priorities 2013-14
Enhancing Your Access to Primary Care
Through Health Links across Waterloo Wellington,
• identify and ensure individualized care plans for high system users (top 5%).
• build linkages between health, social services, justice, and other community partners.
Connect more people with a primary care provider, particularly seniors and individuals with complex issues by:
• assessing current primary care capacity throughout Waterloo Wellington and addressing service gaps.
• improving programs such as Health Care Connect to ensure residents who want a primary care provider can get one.
Share leading practices to improve availability of same day appointments, after-hours availability, telehomecare and home visits.
Expand the centralized intake process for diabetes services to the remainder of the WWLHIN.
Identify opportunities to expand successes in diabetes coordination model to support people with other chronic diseases.
Develop a Centre of Excellence for eHealth to lead initiatives including:
• increasing the adoption and use of Clinical Connect.
• supporting clinicians to use their Electronic Medical Records (EMRs) to improve quality, access to care and health service planning.
• ensuring primary care providers receive timely information when their patients go to the hospital, and leave the hospital including a discharge summary and list of medications.
For more information please visit:
www.wwlhin.on.ca
Creating a More Seamless and Coordinated Healthcare Experience
Integrate hospice palliative care services across sectors and providers.
Complete the implementation of the Acquired Brain Injury (ABI) integration plan.
Implement an integrated regional program for Adult Day Programs, including a standardized model of service based on best practice.
Implement integrations of addictions and mental health services with consideration to the recommendations of the Support Coordination Review, Assertive Community Treatment Teams review and Addictions Services Review.
Implement coordinated access for mental health and addictions services.
Continue to pursue service and back office integrations to improve client experience, health outcomes and value for money in all sectors.
Ensure residents get the right care in the community based on the complexity of their needs by defining and adjusting WWCCAC and Community Support Services functions.
Improve access to short-stay transitional and respite beds.
Develop opportunities to further enhance the WWLHIN Long-Term Care environments such as through specialized behavioural care.
Identify duplication and streamline system navigation services, freeing up capacity in the system to support more frail elderly.
Leading a Quality Healthcare System Using Evidence-based Practice
Develop a Local Quality Partnership to bring local clinical and system leaders together to improve the quality of local care.
Improve the quality of services through the roll out of Quality Based Procedures.
Implement the regional integrated program for stroke care which will include the establishment of a dedicated acute stroke unit and specialized rehabilitation services.
Complete the next phase of implementation for a regional program for Rehabilitative Care which will include care pathways based on best practices implemented consistently across WWLHIN.
Implement six new regional clinical programs which will include the establishment of a program sponsor and clinical councils for each program, identification of standards and care pathways and a move towards more equitable access and consistency of quality across Waterloo Wellington:
• Addictions/Mental Health
• Cardiac
• Critical Care with an initial focus on closed access ICUs
• Emergency
• Pharmacy, starting with microbial stewardship
• Surgery , with an initial focus on Quality-Based Procedures (QBPs)
Implement an integrated wound management program across the continuum of care.
Implement the provincial life or limb policy across Waterloo Wellington.
Each regional program council will establish standards, monitor key metrics and make system improvements within the program. The WWLHIN will continue to hold providers accountable through the HSAA for meeting standards set both by the province and locally.
Ontario
Waterloo Wellington Local Health Integration Network

The Transformation Agenda for Waterloo Wellington

Waterloo Wellington residents continue to invest tax dollars in a healthcare system that is improving, but as we have heard, not yet fully meeting our residents' needs. This is a plan for all our residents and includes consideration of the varied needs of our diverse communities.

The local system plan can only be achieved if everyone, including, WWLHIN board and staff, Local Health Service Providers - their governors, leadership and staff - along with doctors, other professionals and the rest of the community work toward the same objectives and outcomes under a common strategy.

This plan establishes the clarity and focus needed to achieve the right results for our residents. All providers, clinicians and staff in our local health care system need to align with the strategy so that residents may benefit from outcomes laid out in the plan.

Our local priority in facilitating these rapid changes is to break down artificial barriers that exist in the system, so providers have the freedom to redefine and rebuild services in a way that they know will meet the growing needs of the patients and clients they serve.

The Board of Directors of the Local Health Integration Network will work together with governors of Health Service Provider Agencies across Waterloo Wellington to ensure alignment with the strategy for the local health system.

The graphic on the next page summarizes each of the activities within each of the strategic priorities for Waterloo Wellington. The initiatives in each of the strategic priorities are inter-related as, due to the interconnected nature of the health system, initiatives identified in one strategic priority area often impact or relate to other priorities as well.

Our Priority:

Enhancing Your Access to Primary Care

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

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

Ontario's Action Plan for Health Care recognizes family healthcare as the hub of our health system. This has been referred to as an individual's home-base where they go for primary care, information, advice, and access to needed care and supports from the broader health system of care. A strong relationship between our residents and our doctors, nurse practitioners, or other primary care providers is the foundation in building an effective and efficient healthcare system – one that achieves better health, better care and better value and brings Waterloo Wellington one step closer to being the best place to live and grow old in Canada.

To fully realize the benefits of having family healthcare as the hub, we need to ensure our residents have that home-base attachment to a primary care provider or health team and that all primary care providers are well connected within the full continuum of care. This will allow our healthcare professionals to make the best health decisions in developing healthcare plans for residents and, create ease in coordinating timely and effective transitions in service with other providers within those care plans.

We will continue to work alongside primary care providers in Waterloo Wellington to develop an understanding of the needs and pressures within the community by engaging stakeholders that include: primary care providers and family health teams, Health Links, Waterloo Wellington Community Care Access Centre (WWCCAC), hospitals, community services and long-term care homes as well as broader community partners.

The Opportunity:

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

Key initiatives to achieve our strategic priority:

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

- Through Health Links across Waterloo Wellington,
  - identify and ensure individualized care plans for high system users (top 5%), and
  - build linkages between health, social services, justice, and other community partners.

Improve timely access to primary care.

- Connect more people with a primary care provider, particularly seniors and individuals with complex issues, by
  - assessing current primary care capacity throughout Waterloo Wellington and addressing service gaps, and
  - improving programs such as Health Care Connect to ensure residents who want a primary care provider can get one.

- Share leading practices to improve availability of same day appointments, after-hours availability, telehomecare and home visits.

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

- Expand the centralized intake process for diabetes services to the remainder of the WWLHIN.
- Identify opportunities to expand successes in diabetes coordination model to support people with other chronic diseases.

Improving timely information sharing between primary care and other providers.

- Develop a Centre of Excellence for eHealth to lead initiatives including:
  - Increasing the adoption and use of Clinical Connect, and
  - Supporting clinicians to use their Electronic Medical Records (EMRs) to improve quality, access to care and health service planning.
  - Ensuring primary care providers receive timely information when their patients go to the hospital, and leave the hospital including a discharge summary and list of medications.

Expected outcomes for Waterloo Wellington Residents:

- More than 500 high need residents will have an individualized care plan through a Health Link in Waterloo Wellington.
- More than 75% of people registered with Health Care Connect will be connected with a primary care provider.
- 1,333 fewer people will visit the Emergency Department (ED) for minor issues, reducing Emergency Department visits best seen elsewhere to 10.3%.
- 1,200 additional users will use ClinicalConnect® to improve access to their patients' health records.
- Hospital Report Manager will be available to all primary care providers to allow timely access to patient information.

Potential risks/barriers to successful implementation of the initiatives:

- Identification of high users can be difficult to determine and may delay the development of care plans to those that are most complex.
- Health Links are based upon voluntary collaboration between health service providers. Sustaining a long term interest in collaboration may be challenging if early successes are not achieved.
- Some of the issues affecting the outcomes for high users are not related to health issues but to the broader social determinants of health, such as lack of supportive housing, which may not be solvable in the short term or within the health care providers' jurisdictions.
- The success of shared care plan is dependent on the resident and/or family taking an active role in their health care. Residents may be unwilling or unable to modify behaviours, or may have difficulty understanding the changes required (e.g. language issues, mental health issues, health literacy etc).
- Engagement of physicians and other primary care providers who are in a non-FHT or CHC models is more challenging and may limit ability to expand services and programs to impact the broadest number of residents.
- Differing interpretations on privacy regulations may limit provider's willingness to share appropriate information.

- Funding models within primary care may impact the ability to fully implement all types of necessary changes.

- Some of the most complex individuals may not have an OHIP card or primary care provider, resulting in a delay in health services.

- Inconsistencies in data collection and varying collection methods by health care providers make it difficult to develop base line data and to measure improved outcomes.

- Improving the health of the population is a long-term strategy. Results will be seen over the mid- to longer- term and will require commitment and patience to experience the results.

Key enablers to achieve outcomes:

- The establishment of Health Links as primary care hubs to better coordinate care for high-needs patients including seniors and others with complex conditions.

- Continued support from the Ministry to remove barriers to allow our local team to build more links across the health system. This is demonstrated by the development of Ontario's Seniors Strategy to improve quality of care and life for older Ontarians, the implementation of the Ontario Diabetes Strategy to improve quality of care for people living with diabetes and the establishment of Health Links to support the high users of the health system.

- Continue to expand the use of Electronic Medical Records in primary care as well as in specialist offices.

- Electronic sharing of clinical information to enable care providers from across the continuum of care to have up-to-date patient information and improve outcomes.

- Health system management data and analysis that is closer to 'real time' to assist health system managers in deploying effective services focused on local needs.

- WWLHIN Primary Care Physician Lead to assist in connecting with the diversity of primary care providers to help create a shared vision, and demonstrate the value of change, as well as supporting natural leaders and champions in each region

- All-of-community approach to addressing the Social Determinants of Health and Chronic Disease Prevention and Management to improve health outcomes for residents.

Our Priority:
Creating a More Seamless and Coordinated Healthcare Experience

Our residents tell us they do not always know where to go to get the care they need. Some care providers say that even when they know what care is needed, they often do not know the best place to send patients. In the transitions, or handoffs, between providers there lies great risk to quality of care; this can often lead to repeat use of the healthcare system, whether it is Emergency Department visits or readmissions; or gaps in care which could negatively impact health outcomes. We need to create a more seamless experience of care that enables better health outcomes and ensures that our residents receive the right care, at the right place, at the right time.

Navigating the healthcare system is especially difficult for those with the most complex needs. Approximately one per cent of those residents who accessed our local healthcare services in 2009/10 (1,400 residents) accounted for upwards of 20 per cent ($145M) of total health care costs in the same year – equivalent to the operational budget of a community hospital for one year. Further, 8,400 residents or five per cent of total health system users accounted for almost $330M in total health care costs. This five per cent of the population represents the most complex and vulnerable people in our community – a group that requires greater assistance in accessing the right care, at the right place, at the right time.

Changes to how we need to deliver care to older Ontarian's have been highlighted as a priority in the Provincial Seniors Strategy, informed by Dr. Samir K. Sinha's 2013 report *Living Longer, Living Well.* The Change Foundation's 2012 report entitled: *Loud and Clear – Seniors and caregivers speak out about navigating Ontario's healthcare system* identifies improvements in hand-offs between providers as a priority identified by residents.

Further, the Avoidable Hospitalization Advisory Panel (2011) states that: "Hospital readmissions can be seen as a signal of system failure: they often occur because of gaps in care and communications as patients transition from the hospital setting to the next setting of care (home, community care, long-term care home, etc…), and reflect the complexities of the transitions in a health care system in which care is delivered by multiple health service providers with different accountabilities." The same report estimates that in 2008/09 unplanned 30-day readmissions accounted for $705 million in Ontario hospital costs.

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

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

The Opportunity:

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

Key initiatives to achieve our strategic priority:

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

- Integrate hospice palliative care services across sectors and providers.
- Complete the implementation of the Acquired Brain Injury (ABI) integration plan.
- Implement an integrated regional program for Adult Day Programs, including a standardized model of service based on best practice.
- Implement integrations of addictions and mental health services with consideration to the recommendations of the Support Coordination Review, Assertive Community Treatment Teams review and Addictions Services Review.
- Implement coordinated access for mental health and addictions services.
- Continue to pursue service and back office integrations to improve client experience, health outcomes and value for money in all sectors.

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

- Ensure residents get the right care in the community based on the complexity of their needs by defining and adjusting WWCCAC and Community Support Services functions.
- Improve access to short-stay transitional and respite beds.
- Develop opportunities to further enhance the WWLHIN Long-Term Care environments such as through specialized behavioural care.
- Identify duplication and streamline system navigation services, freeing up capacity in the system to support more frail elderly.

Expected outcomes for Waterloo Wellington Residents:

- Fewer days spent in hospital when you should be receiving care elsewhere - Alternate Level of Care days in hospitals – Target 9.46%.
- Residents will not need to be readmitted to the hospital within 30 days of discharge (for selected Case Mixed Groups) - Target 14%.
- Fewer people will go back to the Emergency Department within 30 days for Mental Health Conditions – Target 13.2%.
- Fewer people will go back to the Emergency Department within 30 days for Substance Abuse Conditions – Target 18.1%.
- Residents will get more timely CCAC in-home services - Target 5 days from CCAC application to first assessment and 13 days from first assessment to first service.
- Residents will get more timely CCAC in-home services after hospital discharge – Target 5 days from discharge to CCAC first visit.

Potential risks/barriers to successful implementation of the initiatives:

- As individuals remain in the community longer, community providers are serving higher acuity patients; community services may not be designed to support the level of acuity that they are seeing within their organizations (e.g. human resources, program design, etc.).
- The health and well-being of residents must be placed before the needs of individual organizations.
- Differing interpretations on privacy regulations may limit providers' willingness to share appropriate information.
- WWCCAC performance improvement is underway and is important to the overall health system.
- Proposed solutions, such as additional navigators, may add unnecessary steps/handoffs to the patient experience as opposed to making it easier.
- Potential for incongruent timelines for regional eHealth solutions impacting overall key initiatives.

Key enablers to achieve outcomes:

- Health Service Provider boards prioritizing system integration initiatives as exemplified by board motions and related strategic planning.
- Standardization of reporting practices and business tools used across sectors.
- Expandable eHealth solutions that enable:
  - The sharing of up-to-date clinical information at point-of-care to ease transitions and help the coordination of services through distance/remote communication for healthcare monitoring and provision.
  - Patient/family and health care professional education
  - Real-time health system management data.
- Key expert reports and recommendations that drive health system policy and planning.
- Identifying duplicate and streamlining services to free up capacity to provide more services to residents.

Our Priority:
Leading a Quality Healthcare System Using Evidence-based Practice

The nature of healthcare has changed over the last several decades. It has become progressively more specialized and increasingly relies on expensive equipment, specialized treatments, and highly skilled care professionals who are often in short supply. There has been a growing mismatch between the needs of patients, the best-practice evidence regarding care provision, and the design of the health system. The health system can be improved not only to provide better quality of care and value for money, but also to be easy for residents to navigate. The time for more significant change is now.

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

In Waterloo Wellington a plan is unfolding to redesign the delivery of healthcare services using a regional program model. A regional program is a single standard of care that is based on best practice evidence for specific patient groups. A regional program ensures the same standard of care and access to service for residents regardless of where they may receive that care.

In Waterloo Wellington we have implemented a regional approach to cancer care. In the past cancer services were fragmented across Waterloo Wellington and patients might have received different treatment based on where they happened to live or how they accessed the system. Outcomes for patients were often quite different. That's not the case anymore. Local care for cancer is organized as a regional program and all residents receive the same access and high standards of care. Quality and patient outcomes are also carefully monitored to help us understand what's working and why, and what still needs to be changed.

We know this regional program approach works in Waterloo Wellington and our regional cancer care program has demonstrated results that are better than the provincial average in key areas.

Five year survival rates across lung, breast, prostate and colorectal cancers have all improved according to the most recent Cancer System Quality Index results. These improvements reflect in part a better coordinated system of cancer care for our residents. We've learned from our experience with cancer, diabetes and renal care, and are going to apply this regional program approach right across the Waterloo Wellington health system – starting with Rehabilitation and Stroke care.

A regional system of quality care is fair for everyone, has drastically reduced delays in receiving treatment and has resulted in better quality and outcomes for patients.

The Ministry of Health and Long-Term Care is supporting our system to become more sustainable and to improve quality. Together, we are working to transition from provider-focused lump-sum funding towards a far more transparent patient-centred model, where funding is based on the quality of the care provided.

Quality care is determined by*:

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

* *Quality Improvement Guide*, Health Quality Ontario.

To monitor if changes to the system are resulting in better quality, access and value for money, we monitor a set of key indicators. The Waterloo Wellington health system has achieved significant accomplishments on key provincial benchmarks, such as reducing the number of days patients spent in hospital when requiring an alternative level of care, and decreasing wait times for emergency department care, diagnostic and surgical procedures. Holding our gains on our successes as well as improving on our full list of provincial benchmarks will continue to be a focus of the Waterloo Wellington LHIN and our Health Service Providers in order to deliver quality care to our residents and make Waterloo Wellington the best place to live and grow old in Ontario.

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

The Opportunity:

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

Key local health system initiatives to achieve our strategic priority:

Create one truly integrated and sustainable system of acute care.

- Develop a Local Quality Partnership to bring local clinical and system leaders together to improve the quality of local care.
- Improve the quality of services through the roll out of Quality Based Procedures.

Develop and implement a Waterloo Wellington-wide system-level plan for clinical care services.

- Implement the regional integrated program for stroke care which will include the establishment of a dedicated acute stroke unit and specialized rehabilitation services.
- Complete the next phase of implementation for a regional program for Rehabilitative Care which will include care pathways based on best practices implemented consistently across WWLHIN.

Create regional programs across the health system to provide specific care pathways, ensuring access to evidence-based care.

- Implement six new regional clinical programs which will include the establishment of a program sponsor and clinical councils for each program, identification of standards and care pathways and a move towards more equitable access and consistency of quality across Waterloo Wellington:
    - Addictions/Mental Health
    - Cardiac
    - Critical Care with an initial focus on closed access ICUs.
    - Emergency
    - Pharmacy, starting with microbial stewardship
    - Surgery , with an initial focus on Quality-Based Procedures (QBPs)
- Implement an integrated wound management program across the continuum of care.

Implement initiatives to improve patient safety such as regional life or limb policy, that will ensure the transfer of critically ill patients to the closest, most appropriate care institution, in the most efficient, expedited and safest way possible.

- Implement the provincial life or limb policy across Waterloo Wellington

Implement evidence-based practices to ensure the same high-quality standard of care is provided across all sites for similar services and achieve all access to care and other MLPA metrics.

- Each regional program council will establish standards, monitor key metrics and make system improvements within the program. The WWLHIN will continue to hold providers accountable through the HSAA for meeting standards set both by the province and locally.

Expected outcomes for Waterloo Wellington Residents:

Residents will experience improvements in the quality of their care. Below are some specific metrics that will be used to identify those improvements. Other outcomes will also be considered as part of the roll out of Quality Based Procedures related to health outcomes and sustainability. The WWLHIN will also monitor the implementation of the regional clinical programs in meeting milestone targets over the year.

- Patients requiring admission from the emergency department will be transferred to a hospital bed in a timely way - 90th Percentile ED Length of Stay for Admitted Patients - Target 8 Hours.

- Patients with complex needs requiring care in an emergency department will be seen and sent home in a timely way - 90th Percentile ED Length of Stay for Non Admitted Complex Patients – Target 8 Hours.

- Patients with minor, uncomplicated needs requiring care in an emergency department will be seen and sent home in a timely way - 90th Percentile ED Length of Stay for Non Admitted Minor Uncomplicated Patients – Target 4 Hours.

- Residents will obtain non-urgent MRIs within the provincial target timeline - 90th percentile wait times for non-emergency diagnostic magnetic resonance imaging – Target 28 Days.

- Residents will obtain non-urgent CT scans within the provincial target timeline - 90th percentile wait times for non-emergency diagnostic computed tomography scan – Target 28 Days.

- Residents will receive non-urgent hip replacements within the clinically recommended time - 90th percentile wait time for non-emergency hip replacement – Target 166 Days.

- Residents will receive non-urgent knee replacements within the clinically recommended time - 90th percentile wait time for non-emergency knee replacement – Target 166 Days.

- Fewer stroke patients will be readmitted to hospital after discharge – Target 6%.

- Holding the gains in areas we have already met our targets.
    - 90th percentile wait times for Cancer Surgery – Target 49 days.
    - 90th percentile wait times for Cataract Surgery – Target 166 days.
    - 90th percentile wait times for Cardiac By-Pass Surgery – Target 42 days.
    - 90th percentile wait times Hospital Standardized Mortality Ratio – 100.

Potential risks/barriers to successful implementation of the initiatives:

- System Capacity to lead and manage significant change at the pace that is required.
- Gaining the necessary stakeholder support to ensure a full and smooth implementation.
- A number of funding models that are important for supporting system improvements fall outside of the purview of the LHIN such as emergency physician funding models and Hospital On- Call Coverage Program (HOCC).
- Unknown system reaction to Health System Funding Reform.

Key enablers to achieve outcomes:

- Through the Local Quality Partnership Table, clinical and non-clinical leaders drawn from across the health system will advise on the design and implementation of system improvement initiatives.
- The LHIN will explore the option of creating or expanding Independent Health Facilities to maximize access to care and assure its quality in the context of each clinical program.
- An investment plan that supports strategic priorities for system improvement.
- Ministry of Health and Long-Term Care support in the transition from provider-focused lump-sum funding towards a far more transparent patient-centred model, where funding is based on the quality of the care provided.

ACCELERATING SYSTEM CHANGE

THE TIME TO ACT IS NOW

Our local health system is transforming from a series of fragmented programs/services into a truly integrated system of care that is organized not around organizations, but around our residents.

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

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

Barriers to success will be quickly removed to ensure we generate better health, better care, and better value for you. A much improved system is within reach. To enhance this, we will build knowledge and skills capacity throughout the system in 4 key areas to support the Integrated Health Service Plan: leadership through good governance, quality care, resident-centred care, and integrations and organizational collaboration

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

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

Meeting the Needs of our Diverse Population

As part of our plan development, we have consulted with a number of specific groups including our Francophone and Aboriginal Communities.

With assistance from the French Language Planning Entity for our area and our French residents' survey, we learned more about our local Francophone community. We plan to build on our recent successes in expanded mental health and primary care services for the French community.

We also worked closely with our local Aboriginal community to better understand their demographics and health needs through an Aboriginal Health Needs Assessment. Through this report we confirmed that local Aboriginal residents have much higher rates of many chronic diseases than non-Aboriginal residents, and much lower rates of education and employment.

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

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

French Language Service Plan

The WWLHIN has 15,300 Francophone residents according to the latest data available through the Health Analytics Branch, Ministry of Health and Long-Term Care. While there are no areas in the WWLHIN geography designated under the French Language Services Act, we are committed to improving access to French services for the Francophone community. Our French Language Services (FLS) Coordinator is integrated into all activities of the LHIN to ensure that our work reflects the needs of our local francophone community in the most effective way.

While all of the initiatives outlined in this Annual Business Plan apply to all residents, including Francophone residents, we will continue to implement and initiate new activities that will improve services for Francophone residents. Our Action Plan for 2013-2014 includes:

- Support FLS program initiatives in WWLHIN such as the mental health telemedicine program at the Canadian Mental Health Association- Waterloo Wellington Dufferin, support the multilingual Family Health Team that offer services in French to the WWLHIN residents, and WWCCAC mental health nurses within French schools.

- Continue to work in partnership with the Waterloo Wellington Hamilton Niagara (WWHN) French Language Planning Entity to explore creative solutions to enhance FLS in the Waterloo Wellington health system.

- Participate in inter-ministerial work groups to facilitate access to FLS within the health sector particularly in regard to special needs for students in the French schools.

- In partnership with the Planning Entity, explore leading practices to improve health status of the francophone community especially in regard to chronic diseases management.

- Ensure that FLS are considered in the development of new initiatives.

- Support WWCCAC in the implementation of French services in the community.

- In partnership with Public Health agencies in the WWLHIN, develop an action plan to ensure that the Francophone community is part of the 'Healthy Community' program of those agencies.

- Continue to foster partnerships within the WWLHIN system to ensure Francophone residents have equitable access to services that will result in improved health status.

The work planned for 2013-2014 will reflect the changes in the environment within our LHIN such as the work and recommendations of the Planning Entity and the changes in the demography of the Francophone community which now has a large component of new immigrants and visible minorities.

WWLHIN Operations

The Waterloo Wellington Local Health Integration Network is sustaining the 5% budget reduction, which was originally implemented in 2012/13, and a 10% reduction in its Executive Office budget. In 2012/13 the Waterloo Wellington LHIN took on additional responsibilities from the province. Increases in the budget for 2013/2014 are due to the transfer of these additional responsibilities.

The Waterloo Wellington Local Health Integration Network is committed to continuing to achieve better results than any past health system organization in this area by being innovative in how it carries out its work. We continue to leverage the back office partnership we have with the other 14 LHINs in the form of the *LHIN Shared Service Organization* (LSSO) and the *Local Health System Integration Network Collaborative* (LHINC).

The WWLHIN Operations Spending Plan assumes the following for 2013/14:

- 33 FTEs
- Total Employee Benefits as 20% of Salaries and Wages
- Total Governance Costs are reduced from the 2012/2013 allocation
- Sustained expense reduction for LSSO implemented in 2012/13

WWLHIN Operating Budget for Fiscal Year 2013/14

	2013/14 Budget	2012/13 Actual	2012/2013 Budget
REVENUE			
Operating	4,198,719	4,198,719	4,198,719
Diabetes RCC	1,057,284		
Total Base Revenue	**5,256,003**	**4,198,719**	**4,198,719**
Aboriginal Planning	5,000	5,000	5,000
Diabetes RCC one-time	284,000	260,214	-
eHealth Ontario	-	580,000	510,000
French Language Health Services	106,000	106,000	106,000
ED Lead	75,000	75,000	75,000
Critical Care Lead	75,000	75,000	75,000
Primary Care Lead	75,000	75,000	75,000
ED/ALC Lead	100,000	100,000	100,000
Total One-Time Revenue	**720,000**	**1,276,214**	**946,000**
TOTAL REVENUE	**5,976,003**	**5,474,933**	**5,144,719**
EXPENSES			
Salaries & Benefits	4,466,868	3,632,790	3,642,555
Salaries, Wages, Benefits	**4,466,868**	**3,632,790**	**3,642,555**
Public Relations & Advertising	65,600	100,802	65,600
Consulting Services	150,000	95,834	208,465
Supplies	57,333	52,740	61,873
Mail, Courier, Telecomm	60,000	48,556	64,652
Travel	44,000	25,579	64,941
Printing & Translation	47,575	40,800	47,575
Training & Development	59,500	34,430	49,050
Computer Equipment	49,303	70,948	39,720
Direct Operating Costs	**533,311**	**469,689**	**601,875**
Occupancy	404,719	391,334	336,719
Shared Services	356,620	393,210	341,620
LHIN Collaborative	47,500	47,500	47,500
Other Fixed Costs	**808,839**	**832,044**	**725,839**
Board Chair Per Diems	72,800	73,475	72,800
Board Per Diems	48,250	39,175	62,200
Board Travel	8,750	8,778	13,068
Other Governance Costs	37,185	49,135	26,382
Governance Costs	**166,985**	**170,563**	**174,450**
TOTAL EXPENSES	**5,976,003**	**5,105,087**	**5,144,719**
TOTAL SURPLUS/(DEFICIT)	**0**	**369,846**	**0**
FTE Count	33		27

Note: Increases in budget and staff reflect the move of the Regional Diabetes Coordination Centre to the LHIN.

Waterloo Wellington LHIN
Communications Plan

The Annual Business Plan (ABP) is one of two documents that guide the work of our Local Health Integration Network and our health service providers. Under the *Local Health Systems Integration Act* (LHSIA) 2006, and the *Ministry-LHIN Performance Agreement* (MLPA), Local Health Integration Networks are required to publish an Annual Business Plan to inform stakeholders about the local strategies and initiatives that will be undertaken to achieve the strategy outlined in the local health system's Integrated Health Service Plan.

Our current *Integrated Health Service Plan (IHSP 2013-2016)* identifies three strategic priorities of focus. Within each of the three priorities, a number of system improvement initiatives are needed. We know what has to be done. We must now make those changes as quickly and seamlessly as possible and make sure that all of our health service providers answer the call to immediate action too.

The key feature of our new IHSP is the deliberate move to plain language and less healthcare-specific terminology. For many years this document has been of value to Health Service Providers but those who do not have a healthcare background may have found it less accessible. The IHSP is a document for everyone. This document is all about our commitment to our residents and so it only makes sense that our residents are encouraged to see the value in it as much as our healthcare community does.

Our resident-focused approach will carry through in all of our forward communications. Our local strategy and our key priorities to improve the health and well-being of our residents will echo through all that we produce – but like the health system itself, we will look for more efficient ways to improve navigation and understanding. That is our communications goal: to reach our residents, our health service providers, and all of our partners with clarity and alignment in all that we do.

Target Audiences:

The WWLHIN deals with many stakeholder audiences, each with its own, and often differing, understanding of the health care system and the role of the LHIN in planning, integrating and funding the system. This needs to change, alignment is key to our success. In communicating our Annual Business Plan, we need to inform and engage the following audiences.

Local **Residents**

Our **Local Health Care System Providers**

- Boards of hospitals, community service agencies, community health centres, Community Care Access Centre, mental health and addictions agencies and long-term care homes
- Physicians, nurses, other clinicians and staff
- Administrators of hospitals, community service agencies, community health centres, Community Care Access Centre, mental health and addictions agencies and long-term care homes

Organizations that influence the health and well-being of our residents and the social determinants of health

- Municipalities
- Public Health
- School Boards
- Private Sector
- Ministry of Health and Long-Term Care
- Others

Internal to the Waterloo Wellington LHIN

- LHIN Board of Directors
- LHIN Staff

WWLHIN Advisory Groups and Local Provider Networks

- Local Community Council
- LHIN Health System Leadership Council
- Local Health Professionals Advisory Council
- Primary Care Advisory Council
- Various Networks (Addictions and Mental Health, Community Support Services, Geriatric Services, Emergency Services, etc.)

Other **External Stakeholders**

- MPPs
- Media

Key Messages:

Our key messages will focus on the following:

- The Waterloo Wellington Local Health Integration Network's mission, to lead a high-quality, integrated health system, will be realized through the implementation of strategic priorities and related key initiatives.

- With a focus on our vision of "Better Health – Better Futures" and driven by the core value of "acting in the best interest of our residents' health and well-being", the WWLHIN will generate better health, better care and better value for taxpayers' dollars.

- The health system strategic priorities are: Enhancing Your Access to Primary Care, Creating a More Seamless and Coordinated Healthcare Experience, and Leading a Quality Healthcare System Using Evidence-based Practice.

    - ✓ Enhancing Your Access to Primary Care means helping more residents find a primary care provider, providing timely access to primary care when needed, and improving connections between primary care and the rest of the system.

    - ✓ Creating a More Seamless and Coordinated Healthcare Experience means integrating services to make it easier for residents to effectively navigate the care system and access the right care, in the right place, at the right time.

    - ✓ Leading a Quality Healthcare System Using Evidence-based Practice means changing the way we currently provide care to ensure residents receive high quality care that is based in evidence, focused on the patient, and provides the best possible outcome.

- In order to achieve our three strategic priorities, we must Accelerate System Change. Our local system is transforming from a series of fragmented programs/services into a truly integrated system of care that is organized not around organizations, but around you, the resident.

- The work of the LHINs supports the ministry's Action Plan for Health Care which aims to provide the right care, at the right time, in the right place to ensure better patient outcomes.

- Above all, the Local Health Integration Network is focused on protecting and improving the health and well-being of our residents. Because of the LHINs, for the first time, providers are being held to account to achieve quality outcomes, improve access to care, and ensure value for taxpayer dollars.

- Everyone has a role to play in the change. We are working with local residents, health care providers and others in our community to transform the way health care is delivered, accessed and funded based on evidence, value-for-money and innovation.

- We will undertake to specifically support those leaders, clinicians and organizations that truly put the health and well-being of our residents first by actions that impact all the Triple Aims of Better Health, Better Care and Better Value for taxpayer dollars.

Tactics:

Community Engagement

We live our core value every day at WWLHIN: Acting in the best interest of our residents' health and well-being. To do this effectively, community engagement is central to all the work we do at WWLHIN.

Since their inception in 2005, LHINs have been working closely with residents and local health service providers to identify and plan for local health needs. Community engagement continues to be an essential ingredient in the work of the WWLHIN.

We speak to our residents each and every day. We listen to their experiences in getting the care they need and their feelings about how our local healthcare system is doing. Through our engagement sessions with residents and health service providers, our local community has helped to identify local needs and challenges, suggested solutions, and helped articulate the priorities for change in our local health system.

Ongoing Engagement Activities

Meaningful community engagement supports the WWLHIN's goals to inform, educate, consult, involve and empower stakeholders in health service planning and decision-making processes. Supporting our diverse communities is achieved through a number of engagement strategies including:

- A 15-member **Community Council** meets regularly to provide advice to the Waterloo Wellington LHIN. This is a group of individuals who bring their community knowledge, experience and interest in local health care to the WWLHIN, and in turn, back to the community.

- Our **Local Quality Partnership Table** engages providers to take a system-level perspective on local opportunities to improve performance, increase resources for local services and understand the principles of change management required for the implementation of Health Service Funding Reform (HSFR).

- The WWLHIN's **Health Professionals Advisory Council** meets regularly to provide input into system plans from their professional perspectives.

- The newly created **Primary Care Advisory Committee** provides advice and guidance on how we can implement Health Links across Waterloo Wellington, how to advance electronic information sharing, and how to enhance access to primary care for those residents who want a primary care provider but do not have one.

- The **System Leadership Council**, comprised of leaders from provider networks and stakeholders across the health system, provide input on system initiatives and leadership in accelerating implementation of system change.

- The WWLHIN will continue to reach out to MPPs and other leaders within the community to keep them informed of emerging issues and progress within our area through, newsletters, emails, meetings and conversations.

- We work with local media to keep residents informed of the successes and plans for transforming the health system is a key priority for the Waterloo Wellington LHIN.

- We are building our online community and continuing to grow our social media following and conversations with our local residents. WWLHIN currently manages profiles on twitter, facebook and our newly launched YouTube.

- The Waterloo Wellington LHIN also actively looks for opportunities to engage the community in order to reach broader audiences.

Evaluation

To evaluate the effectiveness of our communications and engagements activities we perform the following activities:

- Tracking reports on resident inquiries and complaints on the local health system.
- Community Engagement trackers
- Feedback forms both paper and electronic via Survey Monkey
- Anonymous surveys
- Facebook insight tools
- Monitoring of Twitter activity
- Bit.ly – online tool to track posting click through results
- YouTube Analytics
- Media monitoring reporting system

Appendix: A

Appendix A

Strategy *Update*

October 25, 2012

This is the first of regular updates on achievement of our strategy to improve the local health system. This provides an update on each of the key initiatives outlined in our Annual Business Plan as actions to address the System Strategic Priorities 2012/13. It also includes the most recent system dashboard.

Future updates will highlight key advancements related to specific initiatives in each priority area and risks to achievement of results.

Enhancing Access to Primary Care

The strategic priority to enhance access to primary health care services is focused on addressing chronic disease prevention and management, decreasing emergency department visits, reducing hospitalization and improving the overall health of the people they serve. Acting in the best interest of the residents of Waterloo Wellington, the following are the key initiatives for this strategic priority:

Connecting unattached patients

In Waterloo Wellington, the Health Care Connect (HCC) staff are developing a strategic plan, and the Primary Care Lead is actively promoting the use of the program. In addition, the new Nurse Practitioner (NP)-Led clinic, located in Cambridge, is now accepting new patients referred by the HCC program.

Impact: The referral rates for the HCC program have been slowly climbing since the program inception (most recent WWLHIN performance 62%), and the number of unattached individuals have been declining (most recent number from Primary Care Access Survey September 2010, 22,000).

Challenges: There are a limited number of Physicians who are accepting new patients through the HCC program and the numbers may not accurately reflect current status of unattached patients in the WWLHIN.

Understanding current access to primary care and developing strategies to promote appropriate access

To better understand access to primary care, a survey of primary care physicians in Waterloo Wellington was conducted to determine use and willingness to implement advanced access. Also, the WWLHIN is working with Groves Memorial community Hospital and north Wellington Health Care to ensure capital projects are aligned with this strategy.

Impact: In Waterloo Wellington, the number of visits to an emergency department that could be better managed in a primary care setting has been decreasing.

Challenges: Advanced access can be difficult to implement in larger practices without appropriate planning or locum availability and physicians indicate that there are many options for ensuring patients have timely access to care.

Primary care model for chronic disease prevention and management

Both the diabetes and the renal care networks in Waterloo Wellington continue to seek opportunities for integration with primary care providers. As well, there is work underway to explore opportunities for expanding a Memory Clinic model to other disease categories and for patients who do not belong to a Family Health Team (FHT). Specialized Geriatric Services are also looking for ways to further integrate with primary care providers in the LHIN.

Impact: As primary care is further integrated into the care continuum to enhance care for those managing chronic diseases, it is expected that hospitalization for ambulatory care sensitive conditions will decrease.

Challenges: The current mind-set of some providers does not consider issues at a system level. Solutions proposed often focus on rostered patients and do not consider adequately population health outcomes of equity.

Improve timely information sharing between providers

Two hospitals in Waterloo Wellington, Grand River Hospital (GRH) and St. Mary's General Hospital (SMGH), are in the early stages of implementing a medication reconciliation program with 2 FHTs and 2 Community Health Centres (CHC). Also the CARE project Team at the Centre for Family Medicine is continuing their work to expand the use of ClinicalConnect, which is an integrated electronic health record, with a scheduled completion date of May 2013.

Impact: These initiatives are anticipated to have a continued positive impact on readmission rates.

Challenges: Because hospitals have competing priorities, efforts on these types of initiatives may not meet timelines for completion as originally planned.

Develop Primary Care Network

The first meeting of the Primary Care Network was held in June 2012 and the Primary Care Lead, Dr. Sabrina Lim Reinders, has been actively engaging providers across the LHIN.

Impact: the Primary Care Network has already provided the WWLHIN Board and Staff with a deeper understanding of the issues facing primary care providers and this has provided the basis for what the priorities for action in this strategic priority need to be.

Challenges: Currently, there is no efficient communication mechanism between the WWLHIN and primary care providers; easier to communicate with FHTs but they only represent 30% of primary care in Waterloo Wellington.

Enhancing Coordination and Transitions of Care for Targeted Populations

The strategic priority to enhance transitions of care is focused on helping people find the right health care when they need it. As well, the focus is on further integrating health care services so that people can easily navigate the health care system. Acting in the best interest of the residents of Waterloo Wellington, the following are the key initiatives for this strategic priority:

Implement the new WWCCAC Client Care Model

The Waterloo Wellington Community Care Access Centre (CCAC) launched their population-based Client Care model in August 2012, which is targeting the needs of residents who have complex and chronic health care needs. The launch of this Model represents an important milestone for the people of Waterloo Wellington who will be better served by the WWCCAC with increased levels of support during transition from one care setting to another.

Impact: As the project implementation progresses, the WWLHIN is anticipating further improvements in ALC rates and reduced wait times for CCAC services.

Challenges: The WWCCAC is currently addressing performance issues with leadership provided by a supervisor Brenda Flaherty appointed by the Minister of Health and Long-Term Care.

Develop and implement integration plans

The WWLHIN is implementing horizontal, vertical and geographical integrations. With a more integrated system, residents will experience high quality care in a much easier way, which will yield better value for money.

Community Support Services: Over the summer, leaders of the community support services organizations in the WWLHIN worked together to create a future end-state model that, once achieved, will improve the delivery of services for our residents. They are considering horizontal integrations within the sector along with linkages with other sectors including primary care. Ideas for change models were received in September 2012.

Addictions: Stonehenge has taken the lead and dedicated their Executive Director to work collaboratively with experts, providers and consumers, to develop the ideal model for addictions services. The project is looking at ways to improve resident access to addictions services by reducing transitions and focusing on the 1-10% of people who use the majority of services. The proposed model of care was recently submitted to the WWLHIN for consideration.

Mental Health: Organizations providing support coordination (case management for mental health clients) and outreach services within the WWLHIN are reviewing best practices and the current state to recommend an end-state model to achieve an optimum level of service provision. In addition, there are two large mental health service providers who have committed to exploring potential partnerships up to and including merger discussions, with the goal to achieve a more optimal level of service provisions for their clients.

Acquired Brain Injury (ABI): The Waterloo Wellington ABI System Coordinator has actively engaged addiction and mental health providers, seeking opportunities to integrate services to meet the needs of residents with an ABI and/or mental health and addictions issues. Alongside this work, a screening tool for people with ABI is now being adopted for use during the intake process for mental health and addiction services, which has facilitated cross training among service providers.

As integration plans are received, the WWLHIN will move forward with the applicable process, depending on whether the integration is voluntary, facilitated, required, or a change in funding.

Impacts: Integrations will have a positive impact on a number of performance targets including: percentage of ALC days in hospitals; repeat unscheduled emergency department visits within 20 days for mental health conditions; and repeat unscheduled emergency department visits within 30 days for substance abuse conditions. For people with an ABI there is also the intended impact of reducing the percentage of ALC days for this specific population who also have mental health and/or substance concerns.

Challenges: Proposed integration models may be overlapping or competing and this will require resolution of the disagreement among stakeholders within sectors and across the continuum of care. The need for integration to improve health outcomes is not accepted by all parties in the system, and providers and associations believe that there is a need to lobby or advocate for their organization.

Implementing Evidence-Based Practice to Drive Quality

The strategic priority to implement evidence-based practice to drive quality is focused on meeting the needs of patients through the design of the health care system and implementation of best practice to achieve better health outcomes. Acting in the best interest of the residents of Waterloo Wellington, the following are the key initiatives for this strategic priority:

Review hospital services and budgets as one system of care

As the March 29, 2012 Board Meeting, WWLHIN Board of Directors directed staff to conduct a review of hospital services and budgets as one system of acute care and reallocate resources to create a fully integrated and sustainable local health system. Since that time, all hospital boards have also passed motions committing to integration, and hospital CEOs have formed a Steering Committee to take the lead on system planning along with key clinical leaders. So far, members of the steering Committee have agreed in principle that regional programs are needed in all major clinical areas. Regional programs include planning care based on best clinical evidence and across the continuum of care while ensuring equitable access to care and quality regardless of where that care may be received. A lead organization for rehabilitation services (including stroke musculoskeletal, cardio-respiratory and frail elderly/complex medical streams) has been identified and work has begun on this program.

Impacts: The WWLHIN anticipates that implementation of regional programs for major clinical areas will reduce readmission rates, improve the quality of stroke care, and reduce the hospital standardized mortality rates.

Challenges: Success of the hospital services review will depend on stakeholder understanding and support, especially clinical leaders and their colleagues throughout the LHIN.

Implement Regional Life and Limb Policy

Waterloo Wellington will implement a Life and Limb Policy to ensure critically ill patients are transferred to the closest, most appropriate care institution. While waiting for further direction from the Critical Care Secretariat, the WWLHIN critical Care Lead has been engaging physician leaders within hospitals to build support for the need for a Life and Limb Policy and to proactively uncover and address potential barriers that may impede the implementation of a Life and Limb Policy. Input from the engagement activities will inform he development of the Policy and once finalized, the project will move to implement the Policy at all WWLHIN hospitals.

Impacts: The Life and Limb Policy will have a positive impact on patient outcomes and quality of care. The key performance target that will be impacted will be the Hospital Standardized Mortality Rate.

Challenges: Development and implementation of the Life and Limb Policy is highly dependent on physician leadership and hospital buy-in. Also, there may be challenges with respect to timing and the ability to engage and educate all of the necessary stakeholders within the timeframe of the project.

Implement the falls prevention strategy

The Waterloo Wellington LHIN has engaged key stakeholders to identify appropriate local leaders to lead a falls prevention program for Waterloo Wellington.

Impacts: With best-practice would protocols being used across the care continuum, patients will experience better quality care and improved outcomes.

Challenges: The timeliness of project completion may be compromised because there are challenges in getting agreement on the framework for the protocol and currently there exists multiple approaches in practice.

Access to Care – Holding the Gains

The strategic priority to hold the gains ensure access to care is focused on maintaining the improvements in the health care system that we have already made and achieving our targets. Acting in the best interest of the residents of Waterloo Wellington, the following are the key initiatives for this strategic priority:

Timely monitoring of key performance metrics and immediate steps to address issues related to both the overall LHIN performance and also specific outliers as needed

The outcome of this objective is to provide the local health system with processes, tools and methods to identify issues and risk, and enable timely action to ensure that performance is improved and maintained. To date, progress includes a system dashboard on our website, development of performance and obligation tracker to better monitor performance and the successful negotiation of the 2012/13 Hospital-Service Accountability Amending Agreements. Work will continue on the following initiatives:

- The M-SAA Year 3 amendment process
- The L-SAA agreement process
- An evaluation of Aging at Home (AAH) – Year 3 initiatives

Development of a publically accessible performance dashboard to enable Health Service Providers and Boards of Directors to access a single source for accurate and timely information

The outcome of this objective is to provide timely, relevant information to health service providers and residents on system performance and to identify system outliers and performance trends. A significant recent achievement in September was the launch of the Waterloo Wellington Health System Decision Support Centre with Cambridge Memorial Hospital as the lead organization. Also, the public can now be informed about how well the local health system is doing by going to the WWLHIN website where the system dashboard depicting the performance targets and results is posted.

Continue to establish shared best-practice initiatives across the Emergency Departments, Diagnostic Imaging Departments, and Surgical practices in the WWLHIN to reduce wait times and protect the safety of residents

The outcome for this objective is to improve resident/patient experience, protect the safety of residents, and reduce system inefficiency. Work is underway to develop a system solution for the MRI/CT Wait Time Strategy, central intake solutions and Emergency Department (ED) – Pay for Results (P4R) Action Plan.

Publicly report surgical and Emergency Department (ED) wait times to inform patient choice

The outcome for this objective is to improve surgical and Emergency Department (ED) wait times by informing patient choice between providers (surgical) and type of care (ED). St Mary's General Hospital is already publicly reporting emergency room wait times and the WWLHIN is working with other hospital to provide this information to our local residents.

Advancing System Enablers to Support Needed Changes

Governance to Governance Engagement

With a new strategic direction in place, it is important that the WWLHIN Board and leadership concentrate efforts on building momentum towards a shared vision for health and healthcare. The most integrated delivery systems have shared values and goals and are integrated across care settings. In July, the Board Chair, Joan Fisk and CEO, Bruce Lauckner hosted sector-specific Strategy Engagement Sessions for the Board Chairs and Vice-Chairs of all of the funded health service provider organizations. These sessions were well attended and feedback from those sessions indicated that the new strategic direction is clear and sets the pat for the journey towards a more integrated health care system. Following the sessions in July, there were sessions held in August and early September for all health service provider board members and leadership teams, which again were an opportunity for the full Board and WWLHIN leaders and staff to engage with the governors of the system and deliver the message of the new strategic direction. Bruce Lauckner clearly outlined that health service providers need to align their plans with the strategic direction for the system and now is the time to move forward with integration plans. Truly integrated health systems create better patient experiences, better health outcomes and maximize value for money.

Along with the strategy engagement session, Joan Fisk, Chair and Dale Small, Vice-Chair of the WWLHIN have been meeting with chairs and vice chairs of the WWLHIN hospitals since January 2012. These meetings have been an opportunity to educate the governors of the hospital sector as well as provide the place for dialogue about how to achieve the system results for residents. These engagement meetings with the hospital governors led to all of the WWLHIN hospitals formalizing their commitment to integration through Board motions at their April and May Board meetings. The last meeting of the hospital governor group was held on September 19, 2012 and the next meeting is planned for January 16, 2013.

Engagement with governors in the system is also conducted by the Board Chair on a routine bases, as she meets with governors of many different health service providers each month. As well, Board members are encouraged to attend the Board meetings for WWLHIN health service providers. During May and June, all of the WWLHIN board members had the opportunity to attend at least one Annual General Meeting for a health service provider. Another facet of the governor engagement is that health service providers are strongly encouraged to attend WWLHIN meetings each month.

Moving forward, the governor to governor engagement activities will be focused on building capacity to lead the health care system. Through education sessions at the Board meeting, the Champions of Change event, which is planned for December 10, 2012 and opportunities to present at health service provider meetings, the Board has been and continues to be very engaged with the governors in the system, to enable the bold changes that need to happen as we continue to lead an integrated health system for the residents of Waterloo Wellington.

CARE Project

The CARE Project's objective is to expand the clinical use of the integrated electronic record (iEHR) platform ClinicalConnect to 2000 clinicians in the LHIN by Q2 2013/14.

The project, funded by eHealth Ontario is achieving good success and since Q4 2011/12 has worked with over 800 clinicians who now have access to and are using the clinical information viewer. The project team is led by the Centre for Family Medicine (Kitchener FHT) and is focused on helping clinicians change manage the adoption of the iEHR into daily practice. CARE is a foundation initiative of the cSWO project.

The ClinicalConnect information viewer aggregates hospital and CCAC clinical information from across both the HNHB and WWLHIN geographies.

Centralized Telemedicine Service

The Centralized Telemedicine Service implementation project's purpose is to build capacity in the WWLHIN for Expanded clinical use of Telemedicine. St Joseph's Health Centre (SJHC) Guelph is leading the effort and is responsible to work with care providers across Waterloo Wellington and beyond in order to create an environment where clinical use of telemedicine can grow. The project is funded by the WWLHIN and leverages the investment made by the Ministry of Health and Long-Term Care's 9,000 Nurses initiative to deploy telemedicine nurses in the field. SJHC provides telemedicine service coordination and management of the funding allocation. The project is achieving significant success with increased adoption of telemedicine for service delivery and recently made a public announcement with MPP Liz Sandals in attendance.

System Integrations

Several sectors are in discussion to determine how best to integrate services to deliver better care. eHealth staff are supporting the integrations discussion from a technology implementation and adoption perspective. The sectors in discussion have clearly heard the LHIN direction of systems consolidation and leveraging existing technology deployed to achieve integration objectives.

Ontario Laboratory Information System (OLIS) Adoption

Hospitals in the WWLHIN are integrating hospital laboratory information systems into the OLIS platform. This planning effort is expected to conclude in the third quarter of 2012/13 with implementation expected to begin in the fourth quarter, pending approvals. Also, the OLIS team reached out to local Public Health Units to integrate their client system to the OLIS platform. Another dimension to this project includes supporting eHealth Ontario's efforts locally to integrate primary care EMR systems to OLIS.

Community Care Information Management (CCIM) Integrated Assessment Record (IAR) Implementation and Adoption

The WWLHIN is continuing to support the MOHLTC's CCIM project to implement common assessment records in the various sectors. The projects are progressing as planned and the WWLHIN participates on provincial and south western Ontario steering committees and leads the sector adoption of IAR tools.

Addressing the root causes of poor health

The Waterloo Wellington LHIN continues to provide local leadership in bringing awareness to and addressing the social dominants of health. Discussions are underway for an all-of-community approach to addressing social determinants in Waterloo Region, Guelph and Wellington County. These efforts have built relationships across health, police services, municipalities, school boards, business leaders and others.

Supporting implementation of the new patient-based funding

It's important that funded organizations have an adequate level of understanding of the new patient-based funding methodology. Currently, there are varying levels of understanding coupled with different ways of tracking costs. As part of the acute service planning, the WWLHIN is initiating a committee to better understand the patient-based funding and integrate into planning for quality programs.

WATERLOO WELLINGTON LOCAL HEALTH INTEGRATION NETWORK
LOCAL HEALTH SYSTEM PERFORMANCE INDICATORS

ACCESS TO CARE - HOLDING THE GAINS

	Performance Indicator 90th Percentile Wait Time: 9 out of 10 adult patients receiving a surgical procedure / diagnostic scan in the number of days stated or less 90th Percentile ER Length of Stay: 9 out of 10 patients visiting the emergency department receiving care in the number of hours stated or less	System Performance Starting Point*	Improvement from System Performance Starting Point	Provincial Target	Most Recent Performance Relative to Provincial Target	Preliminary Local Health System Target**	Most Recent Performance Relative to Preliminary Local Health System Target** - WWLHIN	Most Recent Performance Relative to Preliminary Local Health System Target** - Breakdown by Provider							
								CMH	GGH	GMCH	GRH	NWHC	SMGH	WWCCAC	Most Recent Reporting Period
1	90th Percentile Wait Times for Hip Replacement (non-emergency)	418	61%	182 days	164 ↔	166 days	164 ↔	210 ↘	328 ↗	NA	103 ↘	NA	NA	NA	Sep 2012
2	90th Percentile Wait Times for Knee Replacement (non-emergency)	447	56%	182 days	195 ↘	166 days	196 ↘	198 ↘	332 ↗	NA	112 ↘	NA	NA	NA	Sep 2012
3	90th Percentile Wait Times for Cancer Surgery (non-emergency)	68	26%	84 days	50 ↗	49 days	50 ↗	49 ↔	72 ↗	NR	58 ↗	NA	43 ↘	NA	Sep 2012
4	90th Percentile Wait Times for Elective Isolated Coronary Artery Bypass Graft Surgery	146	83%	182 days	25 ↔	30 days	25 ↔	NA	NA	NA	NA	NA	25 ↔	NA	Sep 2012
5	90th Percentile Wait Times for Cataract Surgery (non-emergency)	274	51%	182 days	135 ↗	166 days	135 ↗	99 ↗	155 ↔	NA	NA	NA	85 ↗	NA	Sep 2012
6	90th Percentile Wait Times for Diagnostic Magnetic Resonance Imaging Scan (non-emergency)	224	66%	28 days	76 ↗	28 days	76 ↗	95	18 ↘	NA	90 ↗	NA	NA	NA	Sep 2012
7	90th Percentile Wait Times for Diagnostic Computed Tomography Scan (non-emergency)	132	80%	28 days	27 ↘	28 days	27 ↘	14 ↘	16 ↘	NR	35 ↘	NA	32 ↘	NA	Sep 2012
8	90th Percentile ER Length of Stay for Admitted Patients	29.0	32%	8 hours	19.7 ↘	8 hours	19.7 ↘	24.9 ↘	10.9 ↘	10.7 ↘	20.4 ↘	NR	20.8 ↗	NA	Aug 2012
9	90th Percentile ER Length of Stay for Non-Admitted Complex Patients	7.7	6%	8 hours	7.2 ↘	8 hours	7.2 ↘	6.9 ↔	5.8 ↔	5.6 ↘	8.1 ↘	NR	7.4 ↔	NA	Aug 2012
10	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated Patients	5.5	20%	4 hours	4.4 ↔	4 hours	4.4 ↔	4.5 ↔	4.1 ↔	3.8 ↔	4.4 ↘	NR	4.7 ↔	NA	Aug 2012

ENHANCING COORDINATION & TRANSITIONS OF CARE FOR TARGETED POPULATIONS

	Performance Indicator #15 - 90th Percentile Wait Time: 9 out of 10 patients receiving care in the number of days stated or less	System Performance Starting Point*	Improvement from System Performance Starting Point	Provincial Target	Most Recent Performance Relative to Provincial Target	Preliminary Local Health System Target**	Most Recent Performance Relative to Preliminary Local Health System Target** - WWLHIN	Most Recent Performance Relative to Preliminary Local Health System Target** - Breakdown by Provider							
								CMH	GGH	GMCH	GRH	NWHC	SMGH	WWCCAC	Most Recent Reporting Period
11	Percentage of Alternate Level of Care (ALC) Days	20.88%	31%	9.46%	14.51% ↗	9.46%	14.51% ↘	20.92%	14.88%	11.23%	12.76%	17.94%	11.65%	NA	Jan-Mar 2012
12	Readmission within 30 days for Selected Case Mixed Groups (CMGs)	15.59%	-1%	TBD	TBD	14.00%	15.68% ↗	18.29% ↗	18.05% ↗	17.92% ↗	9.09% ↘	15.49% ↗	16.10% ↗	NA	Oct-Dec 2011
13	Repeat unscheduled ER visits within 30 days for Mental Health Conditions	15.40%	3%	TBD	TBD	13.20%	14.96% ↔	16.02%	16.43%	11.94%	14.03%	NV	16.51%	NA	Oct-Dec 2011
14	Repeat unscheduled ER visits within 30 days for Substance Abuse Conditions	20.40%	13%	TBD	TBD	18.10%	17.81% ↘	11.11%	17.53%	26.32%	17.70%	NV	17.86%	NA	Oct-Dec 2011
15	90th Percentile Wait Time from Community for CCAC In-Home Services-Application from Community Setting to First CCAC Service (Excluding Case Management)	77	56%	TBD	TBD	30 days	33.5 ↗	NA	NA	NA	NA	NA	NA	33.5 ↗	Jan-Mar 2012

WATERLOO WELLINGTON LOCAL HEALTH INTEGRATION NETWORK
LOCAL HEALTH SYSTEM PERFORMANCE INDICATORS

ENHANCING ACCESS TO PRIMARY CARE

	Performance Indicator	System Performance Starting Point*	Improvement from System Performance Starting Point	Provincial Target	Most Recent Performance Relative to Provincial Target	Preliminary Local Health System Target**	Most Recent Performance Relative to Preliminary Local Health System Target** - WWLHIN	Most Recent Performance Relative to Preliminary Local Health System Target** - Breakdown by Provider							
								CMH	GGH	GMCH	GRH	NWHC	SMGH	WWCCAC	Most Recent Reporting Period
16	Health Care Connect registered patients referred to physician	13%	385%	NA	63% ↗	47%	63% ↗	NA	NA	NA	NA	NA	NA	63% ↗	June 2012
17	Increased number of residents who are attached to a primary care provider	Indicator Under Development													
18	Reduced ED Visits for non-urgent cases that could have been seen in a primary care setting	Indicator Under Development													
19	Reduced hospitalizations for conditions that could be better managed in the community	Indicator Under Development													

IMPLEMENTING EVIDENCE-BASED PRACTICE TO DRIVE QUALITY

	Performance Indicator	System Performance Starting Point*	Improvement from System Performance Starting Point	Provincial Target	Most Recent Performance Relative to Provincial Target	Preliminary Local Health System Target**	Most Recent Performance Relative to Preliminary Local Health System Target** - WWLHIN	Most Recent Performance Relative to Preliminary Local Health System Target** - Breakdown by Provider							
								CMH	GGH	GMCH	GRH	NWHC	SMGH	WWCCAC	Most Recent Reporting Period
20	Hospital Standardized Mortality Ratio (HSMR)	100	10%	100	90 ↔	TBD	90 ↔	NS	NS	NS	NS	NS	NS	NA	NA
21	Readmission Rates for Diabetes (%)	13.56%	2%	NA	13.33% ↗	TBD	13.33% ↗	0.00%	NV	NV	NV	NV	27.78%	NA	Oct-Dec 2011
22	Readmission Rates for Stroke (%)	6.94%	37%	NA	4.39% ↗	TBD	4.39% ↗	NV	NV	NV	NV	NV	NV	NA	Oct-Dec 2011
23	Proportion of stroke/transient ischemic attack patients treated on a stroke unit at any time during their inpatient stay	30.2%	45%	87.5%	43.9% ↗	87.5%	43.9% ↗	NS	NS	NS	NS	NS	NS	NS	FY 2010/11
24	Risk-adjusted stroke/transient ischemic attack mortality rate at 30 days (per 100 patients)	12.9	-19%	14.3	15.4 ↔	14.3	15.4 ↔	NS	NS	NS	NS	NS	NS	NS	FY 2010/11

PERFORMANCE KEY:

- Performance is at or below MLPA target
- Performance is off target by up to 10%
- Performance is off target by greater than 10%

TRENDING CRITERIA:

- ↗ Trending up by at least 5% of rolling 12-month performance (if 12 months is available)
- ↔ Trending within 5% up or down of rolling 12-month performance (if 12 months is available)
- ↘ Trending down by at least 5% of rolling 12-month performance (if 12 months is available)

LEGEND:

NA	Not Applicable
NR	Not Reported
NS	Not Stated
NV	Volume less than 5
TBD	To Be Determined
*	Starting Point: Performance prior to LHIN or first available data point after creation of LHIN
**	Targets to be finalized by WWLHIN and Ministry of Health and Long-Term Care

For more information, please visit the Ontario Wait Times Web Site.

LAST REFRESH: October 16, 2012

Appendix: B

Waterloo Wellington **LHIN**

STRATEGY *Update*

Appendix: B

January 31, 2013

As leaders of the local health care system, we are making progress on the strategic priorities set out in our Annual Business Plan for 2012/13 which was designed to align with the Mission:

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

Actions and decisions during this quarter continue to demonstrate that the WWLHIN is boldly acting in the best interest of our residents' health and well-being, to improve patients' experience and quality of their care. This update for the third quarter of 2012/13 is an overview of the status of each of the key initiatives in the Annual Business Plan along with the system performance dashboard.

Enhancing Access to Primary Care

The strategic priority to enhance access to primary health care services is focused on addressing chronic disease prevention and management, decreasing emergency department visits, reducing hospitalization and improving the overall health of the people they serve. Acting in the best interest of the residents of Waterloo Wellington, the following are the key initiatives for this strategic priority:

Connecting unattached patients

The success of the Health Care Connect Program (HCC) relies on the leadership of the WWCCAC. The WWLHIN has been working closely with their staff to establish specific deliverables and a plan to achieve them. Executing a meaningful communications plan will be a significant element of this work. The Waterloo Wellington Partnership Coordinator for HealthForceOntario Marketing and Recruitment Agency has also been actively involved to enable the success of this program locally.

Impact: In an effort to increase the number of physicians who are accepting new patients, the WWCCAC has set a goal to double the number of physicians registered with HCC from 12 to 24, by the end of March 2013. In addition, the Primary Care Lead has been educating physicians about the HCC, addressing physicians concerns about the program and encouraging them to participate.

Challenges: When the program began, physicians experienced many challenges. WWCCAC will need to re-educate physicians about the benefits of the program, policy changes that have been made and explain the types of patients currently registered with the program. This issue highlights the need for effective communication and outreach with primary care. There is also a need to increase awareness so unattached patients know about and register with HCC.

Understanding current access to primary care and developing strategies to promote appropriate access

Projects that are aligned with the strategy to promote appropriate access to primary care include the Groves Memorial Community Hospital (Groves) and North Wellington Health Care (NWHC) Capital projects. Both projects are moving through the capital planning process, with Stage 1A of their capital submission receiving endorsement by the WWLHIN Board. For the NWHC capital project, two specific elements were endorsed by the Board; (1) an ambulatory and emergency care redevelopment at the Mount Forest site, and (2) the development of new medical education facilities at both Palmerston and Mount Forest hospitals. These projects entail program and service elements that will enhance access to primary and emergency care in the rural areas of the LHIN and will provide a solid infrastructure foundation to the Rural Wellington Health System Review.

Acute care leaders, as well as leaders from primary care, community, mental health and other sectors, have agreed to move forward collaboratively to look at integration opportunities in rural Wellington. The project will involve developing an integrated health care system that meets the health and health care needs of the residents of Rural Wellington.

For people who are most in need of coordinated and accessible primary care, the MOHLTC established the Health Links program. Approval for a Health Link initiative in Guelph, led by the Guelph Family Health Team, was announced on December 6th, 2012. Through leadership and commitment of the care providers across the continuum of care in a geographic area, Health Links will work to improve patient outcomes by ensuring that patients receive better continuity of care. A key part of this work will be the development of personalized coordinated care plans for patients with complex conditions. Through their business plans, Health Links will determine the best model for individualized care plans that will best meet the needs of patients with complex conditions, including seniors, people with multiple chronic diseases, and patients with receiving treatment for mental illness and addictions. Business plans are due to the MOHLTC in February. In the future, it is hoped that Health Links initiatives will be approved for other areas in the WWLHIN and staff continue to work with providers to further develop proposals.

Impact: The capital projects will support primary care as the hub and help support the integration of services in rural communities. As the Health Link initiative in Guelph becomes operational, those who very much need it will be able to get the right types of health care to improve their quality of life and minimize the unnecessary burden of navigating the health care system.

Challenges: The rigidity of the capital process does not accommodate planning for a campus model of care that the WWLHIN envisions for Groves. WWLHIN staff and senior leadership at Groves and NWHC have been working with the MOHLTC Capital Branch to address how to meet the requirements so that this model of care can be realized for the residents of Centre and North Wellington.

Primary care model for chronic disease prevention and management

The WWLHIN has taken on accountability for the Waterloo Wellington Diabetes Regional Coordination Centre (RCC). The transition is being led by the former Regional Director for the RCC, Debbie Hollahan, who is member of the WWLHIN team as a Senior Manager. This work will become part of the overall strategy to prevent and manage chronic disease among the people of Waterloo Wellington. The resources will be deployed to further support the overall strategy for the WWLHIN, so that the outcome of the accountability shift will be one that is best for the residents.

Impact: The approach to chronic disease prevention and management will be integrated with the activities of the WWLHIN in all of the strategic priority areas.

Challenges: To be successful, the **c**hanging in accountability for the RCC will need to incorporate change management strategies to maintain the momentum achieve the desired outcome.

Improve timely information sharing between providers

The use of ClinicalConnect as a tool to share patient information among different providers continues to expand, with leadership from the Centre for Family Medicine Family Health Team (CFFM FHT). A proposal has been submitted to eHealth Ontario on improving the quality of care. With more physicians using Electronic Medical Records (EMRs) in primary care, it is possible for clinicians to identify patient outcome trends and change practice in response to these trends

The Primary Care Advisory Committee identified the need for all WWLHIN hospitals to provide timely and consistent discharge information, including medication reconciliation, to primary care physicians. This was also raised at the Hospital Governors meeting and noted as an issue that needed to be addressed. Hospitals and the WWCCAC have piloted several projects to improve getting information about patients to primary care providers.

The WWLHIN Primary Care Lead is very involved with these projects, and her leadership is serving to champion the need to prioritize this work in order to provide better care for people.

Impact: Ultimately efforts that focus on timely information sharing result in better care for residents. With more information available, providers make better decisions and the patient experience is less frustrating.

Challenges: Challenges continue with these types of initiatives because there are competing priorities throughout the health care system, and especially in hospitals.

Develop Primary Care Network

The WWLHIN Primary Care Advisory Committee has been developed to engage primary care providers in a dialogue about the implementation of Ontario's Action Plan and the Waterloo Wellington Local Health System Strategy. The Committee is chaired by the Primary Care Lead, and is meeting on a quarterly basis.

The Primary Care Lead, Dr. Sabrina Lim-Reinders, has been meeting with Family Health Teams (FHTs) and Community Health Centre (CHC) physicians. Over the coming months, Dr. Lim Reinders will be engaging with non-FHT physician groups.

Impact: Continued engagement with physicians is a critical success factor for the WWLHIN's strategic priorities and strong leadership from the Physician Lead and Advisory Committee will bring about improvements in the system to ultimately provide better care for patients.

Challenges: As noted in a previous strategy update, it is difficult to connect with physicians who are not part of larger groups such as Community Health Centres or Family Health Teams.. However, the WWLHIN Primary Care Physician Lead is committed to actively engaging this group.

Enhancing Coordination and Transitions of Care for Targeted Populations

The strategic priority to enhance transitions of care is focused on helping people find the right health care when they need it. As well, the focus is on further integrating health care services so that people can easily navigate the health care system. Acting in the best interest of the residents of Waterloo Wellington, the following are the key initiatives for this strategic priority:

Implement the new WWCCAC Client Care Model

The Waterloo Wellington Community Care Access Centre (CCAC) launched their population-based Client Care model in August 2012, which is targeting the needs of residents who have complex and chronic health care needs. Overtime, the CCAC will streamline service offerings towards high risk patients and transition services for lower need patients to other community support service providers.

Impact: With the CCAC's focused attention on improving the health of higher need patients, outcomes will include reduced emergency department visits and hospital admissions, and deferring admission to long-term care. Alignment of clients who have lower care coordination with community support services is consistent with other service integrations underway to create a more a seamless care experience for clients.

Challenges: Personal Support Worker capacity within community service agencies must be developed, and a transition plan for the affected client population is required to ensure continuity of care and minimal impact on clients.

Develop and implement integration plans

Building a more integrated system to improve quality of care and value for money is the foundation for the strategic priorities of the WWLHIN. The patient experience is framing the direction for all actions and decisions related to integration of the health care system. Across all care settings in each of the geographic areas of the WWLHIN, working with their partners, the WWLHIN has been able to articulate what needs to happen. Now it will be important to make this happen in the way that best meets the needs of the people who access health services.

Community Support Services: During the summer of 2012, the WWLHIN sought input from Community Support Services (CSS) providers to provide ideas for integration that would best meet the needs of clients. This input along with submissions demonstrating alignment from all of our health service providers revealed opportunities to integrate services that were already underway. The WWLHIN is supporting completion of this work and the results will initiate improvements for clients. These initiatives are only a beginning; further action is required to move towards the goal of having a single entry experience and a single client-centred plan of care for any client in a particular geographical area.

Addictions: Over the last four months, a number of inputs regarding improvements to the addiction system in Waterloo Wellington have been received by the LHIN, including the Addictions Integration Report submitted by the Board of Directors of Stonehenge Therapeutic Community. Since the December Board meeting, there have been ongoing conversations about change. These include discussions about a number of opportunities, (1) the Opioid Substitution Program, (2) the Specialized Medical and Mental Health Outreach Programs, (3) the integration of services between Stonehenge Therapeutic Community and House of Friendship, and (4) integration through transfer of services provided by St. Mary's Counseling to other agencies.

Mental Health: Important foundational pieces have been put in place develop to a strong system of mental health system care. This element of the strategic priority to improve coordination and transitions of care, is currently comprised of three focus areas: (1) Specialized Medical and Mental Health Outreach Services, (2) An Integrated Approach to Mental Health Services (Trellis Mental Health and Developmental

Services and the Canadian Mental Health Association, Grand River Branch), and (3) Support Coordination Services: Mental health case management and coordinated access to services. The WWLHIN has endorsed the direction for all three of these focus areas, and a lead agency has been named to develop a specialized medical and mental health outreach service. Trellis Mental Health and Developmental Services and the Canadian Mental Health Association, Grand River Branch are continuing their work to further define and progress with the governance, operational, and financial steps that need to take place in order to provide notice of a voluntary integration to the WWLHIN. Following consultation, a lead agency will be recommended to establish a regional program for mental health case management services and coordinated access for mental health services.

Hospice Palliative Care: Waterloo Wellington, with leadership from the WWCCAC as sponsor organization, has developed a local implementation plan for palliative care in keeping with the recent provincial policy review "Advancing High Quality, High Value Palliative Care in Ontario, Declaration of Partnership and Commitment to Action." There is a need to accelerate the implementation, ensuring an integrated approach across all providers. This includes specific consultation and involvement of Cancer Care Ontario, through the Regional Cancer Centre at Grand River Hospital.

In addition, three local providers are working together to develop an enhanced client service model. Governors and leadership of Lisaard House, Hospice Wellington and Hospice of Waterloo Region have informed the WWLHIN of their collective commitment to implement a delivery model that will enhance the outcomes and experiences of patients, and have the potential to engage other service providers. A work plan has been presented, with recommendations and an implementation plan expected in March 2013.

Acquired Brain Injury (ABI):
Work is progressing on the recommendations stemming from the Waterloo Wellington Integrated ABI Service System Overview report of January 2011. While some milestones have been missed, sponsor organizations are aware of the expectation that the work plan be completed in the 3rd quarter of 2013/14 as scheduled. Continued collaboration and focus of the 3 main involved providers: Traverse Independence, St. Joseph's Health Centre (Guelph), and WWCCAC along with the ABI System Coordinator is required in order to fully realize the recommendations. ABI providers are also considering a Regional Program Model approach for ABI that builds on the Cancer Care Ontario's Strategy for Sustainability and Integration Model of Care.

Impacts: By integrating the system, it is possible to free-up resources to focus on improving quality of care. With leadership from the WWLHIN, the health care providers can rise to this challenge and bring about positive changes to improve the overall patient experience in a sustainable way.

Challenges: Integrating the system will necessitate the parties involved to resolve governance, operational and financial issues in order to move forward. The WWLHIN will support this work when it is possible to do so and as long as it is aligned with the strategy to do what is in the best interest of the residents.

Implementing Evidence-Based Practice to Drive Quality

The strategic priority to implement evidence-based practice to drive quality is focused on meeting the needs of patients through the design of the health care system and implementation of best practice to achieve better health outcomes. Acting in the best interest of the residents of Waterloo Wellington, the following are the key initiatives for this strategic priority:

Review hospital services and budgets as one system of care

The decision of the WWLHIN Board on March 29th, 2012, to conduct a review of hospital services and budgets as one system of acute care and reallocate resources to create a fully integrated and sustainable local health system, has led to the a project now known as ***Clinical Services Redesign & Implementation.*** With leadership from a Steering Committee, a draft action plan has been developed to establish regional programs for major clinical areas. The draft action plan has been presented to the WWLHIN Board and hospital Boards, and a leadership forum with governors and clinical leaders took place early in January 2013. Accelerating the pace of this project is a priority for the WWLHIN, and it has been communicated to Steering Committee that support is available to move things forward faster. The WWLHIN has requested an update on this work and how it can be accelerated on January 30, 2013.

The Rehabilitation System of Care project has a finalized charter and the WWLHIN Board approved funding for implementation at the December 6, 2012 meeting. The rehabilitative system of care is comprised of four streams of care, and one of those streams is stroke care.

For the WWLHIN, it is particularly important that progress be made to implement a regional program for people who suffer a stroke. The current state is less than optimal and it is the right thing to do for patients. Funding was approved to implement this program at the December 6, 2012 Board meeting as well. The business case for the stroke care program, with input from experts, is expected to be complete by the end of January 2013, and then communication to the Rehab Care Council and hospital Boards will take place starting in mid-February. To demonstrate their support and commitment to improving care for stroke patients, hospital Boards will need to pass integration motions. The lead organization for this work, St. Joseph's Health Centre (Guelph) will bring forward integrations to the WWLHIN Board before the end of the fiscal year.

Impacts: Through their work at the Steering Committee for the Clinical Services and Redesign Implementation the hospitals have developed a new way of working together, which is supportive of the vision and direction for the acute care system. By establishing regional clinical programs, residents of Waterloo Wellington will realize better quality care throughout the hospital system. To ensure this the vision is realized, the action plan's model recommends that strong accountability structures be established to oversee the regional programs.

Challenges: A key consideration to solidify the success of the Clinical Services Redesign and Implementation continues to be the need for stakeholder understanding and support, especially from clinical leaders throughout the LHIN. The engagement plan and accountability structure will take this into consideration.

Implement Regional Life and Limb Policy

In his role as Critical Care Lead, Dr. Frank Reinders is leading the project to implement the Life and Limb Policy across the WWLHIN. This is a province-wide initiative and progress relies on both local-level and provincial-level work. The MOHTLC is responsible to provide all of the LHINs with the policy by the end of January 2013. At the local level, Dr. Reinders has been educating clinical leaders in preparation for implementation of the policy. His work has enabled issues to be addressed in advance of the policy being implemented on April 1, 2013.

Impacts: This Policy not only will have a positive impact the Hospital Standardized Mortality Rates for WWLHIN hospitals, but most importantly it will avoid unnecessary patient transfers and barriers to repatriation back to the hospital closest to the patient's home.

Challenges: Delay at the provincial level is an issue for this project that is being mitigated by Dr. Reinder's ongoing communication and engagement with stakeholders.

Implement the falls prevention strategy

Initially, the expectation of the Province was that this work would be led by public health units, however, that did not occur. We have identified an opportunity to incorporate this work in the Frail Elderly/Medically Complex stream of care, which is part of the Rehab Council. The patients, who this committee would be developing care pathways for, are the same people who are at the highest risk of falls. The co-chairs have agreed that this would be an appropriate place to falls prevention to land as has the rehab coordinator. This work is now being led by the Frail Elderly/Medically Complex steering committee.

Impacts: By aligning with the local Clinical Services Redesign and Implementation project, the project will be positioned to become part of a broader and more comprehensive approach to care for the elderly who are frail and/or have complex health needs.

Challenges: Originally this project was planned to be completed by the end of February. However there continue to be challenges at the provincial level in regards to achieving an agreed upon approach to the framework for the protocol.

Implement evidence-based best practice wound protocol across the continuum of care

Working with the WWCAC, the hospitals' Chief Nursing Executives (CNEs) have developed a proposal to implement a standard practice for wound care across the health system. Finalization of the protocol will take place mid-January, and next steps will include determination of a lead organization along with participation of a number of different service providers and stakeholders.

Access to Care – Holding the Gains

The strategic priority to hold the gains ensure access to care is focused on maintaining the improvements in the health care system that we have already made and achieving our targets. Acting in the best interest of the residents of Waterloo Wellington, the following are the key initiatives for this strategic priority:

Timely monitoring of key performance metrics and immediate steps to address issues related to both the overall LHIN performance and also specific outliers as needed

The WWLHIN works closely with health service providers to monitor performance metrics and address issues as they arise. Use of the performance and obligation tracker has greatly improved this process. The Service Accountability Agreement refresh process has and will provide an opportunity to establish targets that will result in the best care for the people of Waterloo Wellington.

- 2012/13 Hospital-Service Accountability Amending Agreements (already in place)
- The M-SAA Year 3 amendment process (to be completed by March 2013)
- The L-SAA agreement process (to be completed by January 2013)

Development of a publically accessible performance dashboard to enable Health Service Providers and Boards of Directors to access a single source for accurate and timely information

All stakeholders including the public can find a current local health system dashboard on the WWLHIN website. This dashboard is a valuable tool for staff because it clearly lays out the specific obligations that the WWLHIN has in their Ministry-LHIN Performance Agreement (MLPA). As a health system, the dashboard serves as the compass for all of the projects contributing to the strategy. The Decision Support Centre (DSC) staff are working with the WWLHIN to make improvements to the dashboard, which will eventually be dynamic with some drill-down capability.

In addition to recruiting and operational work, the DSC's efforts are actively supporting many different initiatives across the health system. Projects led by various entities are advancing because of the availability of data and information provided by the DSC. These entities include the WWLHIN, the Rehab Care Council, Stroke Steering Committee, Guelph Health Links and various HSPs. A key priority for the DSC moving forward will be full participation in the Integrated Decision Support (IDS) system that is a cross-LHIN collaborative initiative.

Continue to establish shared best-practice initiatives across the Emergency Departments, Diagnostic Imaging Departments, and Surgical practices in the WWLHIN to reduce wait times and protect the safety of residents

Projects to address this objective are linked to the work for the strategy to implement evidence-based practice to drive quality.

Improving wait times for diagnostic imaging will take a "regional program" approach by expecting all service providers to collaborate and develop mechanisms for patient referral and ensuring patient need is matched to available capacity. For example, MRI service in Waterloo Wellington is provided by four service providers. Waiting time is variable across the providers and the overall access to care target is not being met while, at the same time, excess capacity exists at one of the providers. There is an opportunity to redirect some referrals that will result in more timely service being provided to residents.

To achieve the targets for wait times in emergency departments, the ED lead is working with the Waterloo Wellington Emergency Services Network, to develop practices that focus on the high users of emergency departments and that can be deployed throughout the WWLHIN hospitals. Targets for wait times continue to be a challenge for hospitals in the WWLHIN and specific interventions may need to be introduced. In addition, St. Mary's General Hospital has initiated a plan to embed a coaching team within its operations to implement ED improvements that are scalable and can be spread to other Waterloo Wellington hospital

sites. Grand River Hospital and Cambridge Memorial Hospital have expressed an interest in participating and representatives from all three hospitals recently visited a hospital in the South West LHIN that has achieved impressive results using a similar approach.

Publicly report surgical and Emergency Department (ED) wait times to inform patient choice

If the public has access to information about wait times for the emergency department and non-emergency surgeries, they can be empowered to make decisions about their care.

St Mary's General Hospital (SMGH) has implemented a patient-centred web-based communication tool designed to enable real-time feedback of Emergency Department wait times. The tool provides people with the estimated wait time to see a physician or nurse practioner and provides people with information to make more informed decisions about when and where to seek care. Early results demonstrate that the tool is having a positive impact. Since implementing this tool for people in the community, SMGH has seen a reduction in emergency department visits for people who have minor or less-urgent health concerns. In conjunction, there has not been a corresponding increase in visits from this patient group at Grand River Hospital.By March 31, 2013,Grand River Hospital, Cambridge Memorial Hospital, and Groves Memorial Community Hospital will also make available on their web-site the real-time status of how long waiting times are in their emergency departments.

Advancing System Enablers to Support Needed Changes

The strategic priority to advance system enablers to support needed changes involves activities and projects that are designed to remove barriers to change in the health care system. The scope of this priority incorporates four focus areas; (1) governor engagement, (2) support to implement health system funding reform, (3) addressing the social determinants of health, and (4) eHealth projects. Acting in the best interest of residents, the following are the key initiatives for this priority:

Governance to Governance Engagement

Governors and leaders need to have a shared vision for the health care system, and this principle remains as the basis for engagement with health service provider boards and other leaders in our communities. Meetings with governors have become more specific to the projects that are part of the overall strategy for the system, for example, meetings with Board Chairs of providers who are undertaking integration activities have taken place. The Board Chair has met with a number of her counterparts from various organizations in various sectors across the system for this purpose. Also, there have been a number of meetings with governors and leaders from healthcare and non-healthcare organizations to highlight the role of the WWLHIN and discuss strategic activities to improve the overall health of the population and experience with the health care system. These relationship building meetings have resulting in deeper understanding of the WWLHIN and what needs to be done for the people in Waterloo Wellington.

With support from the Governance Committee, planning is underway for additional health service provider governor education sessions, that will be a forum to learn about the WWLHIN's purpose in leading to achieve a high quality integrated health system, and the health service provider's role in this mission. Providing these sessions will contribute to leadership capacity building among board members who oversee the services provided to our residents. Another capacity building opportunity will be the Integrated Health Service Plan (IHSP) roll out sessions planned for early in 2013, where Governors of health service providers will also have an opportunity to engage with the WWLHIN. Regular meetings with Chairs and Vice Chairs of the hospitals will continue and there are plans to initiate similar gatherings for providers in the community and long-term care sectors.

Supporting implementation of the new patient-based funding

To facilitate implementation of patient-based funding, the Local Quality Partnership (LQP) will be established for the WWLHIN. The LQP will be an advisory group to the WWLHIN, and will be comprised of LHIN and health service provider expertise to facilitate the implementation locally of Health System Funding Reform (HSFR). The purpose of the LQP will be to advance knowledge transfer regarding HSFR, to support the provincial and local management of operational issues, and to support clinical capacity planning in conjunction with the roll-out of quality-based procedures. Currently a Chair is being recruited for the LQP and the first meeting is planned for February.

Addressing the root causes of poor health

The actions in the new Integrated Health Services Plan for 2013 – 2016 are specifically designed to bring about meaningful change for the people who live in Waterloo Wellington. This can only be possible if the community is mobilized to make changes that impact the social determinants of health, and the WWLHIN continues to engage with other key leaders throughout the LHIN

An invitation-only event is planned for January 30th that will be an opportunity for local leaders to attend a presentation and engage in discussion about possibilities for collaboration to improve outcomes across communities throughout the WWLHIN. The presenters at this event will be two leaders from Saskatchewan who spearheaded an initiative across nine ministries of government and the province's

police leaders to mobilize collaborative responses to the risk factors that affect the most marginalized members of society.

Another facet to addressing the root causes of poor health, involves health equity strategies. One of the WWLHIN's corporate objectives is to champion equity in population health and health outcomes, because linguistic barriers and cultural factors have an impact on the health status of residents. Given the increased changes in the demographic portrait of Waterloo Wellington residents, it is important that health care providers integrate cultural competence, including an ability to understand, communicate with and effectively interact with people across cultures and diversities in their everyday practice. In response to this need for capacity building among health service providers, the WWLHIN is working with providers to examine health equity issues in the region.

The first step will be to lead the development by the Waterloo Wellington CHCs of a Cultural Competency training module for all agencies and primary care providers. The components of this training will be based on the one developed by SickKids hospital and mandated by Toronto Central LHIN and it provides the participants an opportunity to understand and reflect on personal biases, assumption and prejudices that can influence the quality of interaction with patients/families and influence care, as well as the link between clinical cultural competence and patient safety, and family/patient-centred care. Moving forward, all service providers are leading the way to improving the health of all residents. The up-coming renewal of the service agreements in all sectors gives the WWLHIN the opportunity to secure the participation of all service providers in acquiring necessary data to inform the future activities in regard to health equity.

Leverage clinical tools that have been proven to improve the patient experience and outcomes, enhance physician's ability to deliver safe, effective care and reduce the number of complications and deaths

There are a number of active projects in the WWLHIN that will move forward with electronic clinical tools to improve quality of patient care. All of these projects are designed to promote the work of the other strategic priorities in the Annual Business Plan.

Common Assessment Tools

Ontario Common Assessment of Need (OCAN)

The Ontario Common Assessment of Need (OCAN) implementation is well underway in the WWLHIN. Six local community mental health providers went live with this electronic tool in 2012. By using OCAN, the professionals, who provide care for people needing mental health care, can focus on individual client needs and provide a more inclusive approach to care. The use of a common language to assess people's needs facilitates matching them with the right types of services, and it makes it possible to engage clients throughout their treatment and recovery. In fact, providers report that OCAN has sparked new, useful conversations with consumers and enhanced their ability to provide focused care.

Two local hospitals remain in the process of implementing OCAN as they have been met with challenges related to integrating the technology into their existing IT infrastructure. However, work continues towards full implementation.

Shared Assessment

Of particular note for WWLHIN, a Shared Assessment model has been implemented. Shared Assessment is a formal process where health service providers work together on OCAN assessments to avoid duplication for clients across multiple health services. Outside of the pilot group (5 Toronto LHINs), the WWLHIN is the first LHIN in the province to implement this model. The WWLHIN providers felt the right approach to implementing the Shared Assessment model be one that occurred concurrently with the implementation of OCAN.

All of the projects and activities are leading to results that will achieve the strategic priorities and impact the performance measures set out in the MLPA for 2012/13. The current dashboard for the health system is provided as a companion to this update.

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WATERLOO WELLINGTON LOCAL HEALTH INTEGRATION NETWORK
LOCAL HEALTH SYSTEM PERFORMANCE INDICATORS

ACCESS TO CARE - HOLDING THE GAINS

	Performance Indicator 90th Percentile Wait Time: 9 out of 10 adult patients receiving a surgical procedure / diagnostic scan in the number of days stated or less 90th Percentile ER Length of Stay: 9 out of 10 patients visiting the emergency department receiving care in the number of hours stated or less	System Performance Starting Point*	Improvement from System Performance Starting Point	Provincial Target	Most Recent Performance Relative to Provincial Target	Local Health System Target	Most Recent Performance Relative to Local Health System Target - WWLHIN	Most Recent Performance Relative to Local Health System Target - Breakdown by Provider							
								CMH	GGH	GMCH	GRH	NWHC	SMGH	WWCCAC	Most Recent Reporting Period
1	90th Percentile **Wait Times for Hip Replacement (non-emergency)**	418	48%	182 days	218 ↗	166 days	218 ↗	133 ↘	259 ↗	NA	83 ↘	NA	NA	NA	Dec 2012
2	90th Percentile **Wait Times for Knee Replacement (non-emergency)**	447	40%	182 days	266 ↗	166 days	266 ↗	71 ↘	270 ↔	NA	83 ↘	NA	NA	NA	Dec 2012
3	90th Percentile **Wait Times for Cancer Surgery (non-emergency)**	68	47%	84 days	36 ↘	49 days	36 ↘	73 ↗	41 ↔	NR	29 ↘	NA	34 ↘	NA	Dec 2012
4	90th Percentile **Wait Times for Elective Isolated Coronary Artery Bypass Graft Surgery**	146	93%	182 days	10 ↘	42 days	10 ↘	NA	NA	NA	NA	NA	10 ↘	NA	Dec 2012
5	90th Percentile Wait Times for **Cataract Surgery (non-emergency)**	274	64%	182 days	99 ↘	166 days	99 ↘	99 ↗	139 ↘	NA	NA	NA	65 ↘	NA	Dec 2012
6	90th Percentile **Wait Times for Diagnostic Magnetic Resonance Imaging Scan (non-emergency)**	224	81%	28 days	42 ↘	28 days	42 ↘	58	20 ↘	NA	48 ↘	NA	NA	NA	Dec 2012
7	90th Percentile **Wait Times for Diagnostic Computed Tomography Scan (non-emergency)**	132	80%	28 days	27 ↘	28 days	27 ↘	15 ↘	11 ↘	NR	37 ↔	NA	28 ↘	NA	Dec 2012
8	90th Percentile **ER Length of Stay for Admitted Patients**	29.0	18%	8 hours	23.9 ↗	8 hours	23.9 ↗	20.9 ↘	14.8 ↗	14.3 ↘	26.6 ↗	NR	31.1 ↗	NA	Nov 2012
9	90th Percentile **ER Length of Stay for Non-Admitted Complex Patients**	7.7	4%	8 hours	7.4 ↔	8 hours	7.4 ↔	6.6 ↘	5.8 ↔	6.4 ↗	8.7 ↘	NR	7.2 ↘	NA	Nov 2012
10	90th Percentile **ER Length of Stay for Non-Admitted Minor Uncomplicated Patients**	5.5	20%	4 hours	4.4 ↔	4 hours	4.4 ↔	4.4 ↔	4.1 ↔	3.7 ↔	5.1 ↘	NR	4.7 ↔	NA	Nov 2012

ENHANCING COORDINATION & TRANSITIONS OF CARE FOR TARGETED POPULATIONS

	Performance Indicator #15 - 90th Percentile Wait Time: 9 out of 10 patients receiving care in the number of days stated or less	System Performance Starting Point*	Improvement from System Performance Starting Point	Provincial Target	Most Recent Performance Relative to Provincial Target	Local Health System Target	Most Recent Performance Relative to Local Health System Target - WWLHIN	Most Recent Performance Relative to Local Health System Target - Breakdown by Provider							
								CMH	GGH	GMCH	GRH	NWHC	SMGH	WWCCAC	Most Recent Reporting Period
11	Percentage of Alternate Level of Care (ALC) Days	20.88%	34%	9.46%	13.74% ↘	9.46%	13.74% ↘	16.48% ↘	13.58% ↘	6.66% ↘	14.79% ↔	8.33% ↘	11.79% ↘	NA	Apr-Jun 2012
12	Readmission within 30 days for Selected Case Mixed Groups (CMGs)	15.59%	6%	TBD	TBD	14.00%	14.64% ↗	15.92% ↗	14.37% ↘	17.74% ↗	13.17% ↔	6.94% ↘	15.58% ↗	NA	Jan-Mar 2012
13	Repeat unscheduled ER visits within 30 days for Mental Health Conditions	15.40%	2%	TBD	TBD	13.20%	15.09% ↔	18.40%	15.65%	NV	9.93%	NV	8.40%	NA	Jan-Mar 2012
14	Repeat unscheduled ER visits within 30 days for Substance Abuse Conditions	20.40%	14%	TBD	TBD	18.10%	17.50% ↘	12.70%	16.15%	NV	23.28%	NV	7.81%	NA	Jan-Mar 2012
15	90th Percentile **Wait Time from Community for CCAC In-Home Services-Application from Community Setting to First CCAC Service (Excluding Case Management)**	77	58%	TBD	TBD	30 days	32 ↗	NA	NA	NA	NA	NA	NA	32 ↗	Apr-Jun 2012

WATERLOO WELLINGTON LOCAL HEALTH INTEGRATION NETWORK
LOCAL HEALTH SYSTEM PERFORMANCE INDICATORS

ENHANCING ACCESS TO PRIMARY CARE

	Performance Indicator	System Performance Starting Point*	Improvement from System Performance Starting Point	Provincial Target	Most Recent Performance Relative to Provincial Target	Local Health System Target	Most Recent Performance Relative to Local Health System Target - WWLHIN	Most Recent Performance Relative to Local Health System Target - Breakdown by Provider							
								CMH	GGH	GMCH	GRH	NWHC	SMGH	WWCCAC	Most Recent Reporting Period
16	Health Care Connect registered patients referred to physician	13%	361%	NA	60% ↗	TBD	60% ↗	NA	NA	NA	NA	NA	NA	60% ↗	Oct 2012
17	Increased number of residents who are attached to a primary care provider	To Be Updated February 2013													
18	Reduced ED Visits for non-urgent cases that could have been seen in a primary care setting (ED Visits Best Managed Elsewhere)	11.18%	-21%	NA	13.56% ↗	TBD	13.56% ↗	11.18% ↗	13.69% ↗	23.73% ↗	7.90% ↗	18.65% ↗	8.73% ↗	NA	Jan-Mar 2012
19	Reduced hospitalizations for conditions that could be better managed in the community (Ambulatory Care Sensitive Conditions)	3.95%	-16%	NA	4.59% ↗	TBD	4.59% ↗	5.50% ↗	5.63% ↗	6.21% ↗	1.92% ↗	3.51% ↘	11.02% ↔	NA	Jan-Mar 2012

IMPLEMENTING EVIDENCE-BASED PRACTICE TO DRIVE QUALITY

	Performance Indicator	System Performance Starting Point*	Improvement from System Performance Starting Point	Provincial Target	Most Recent Performance Relative to Provincial Target	Local Health System Target	Most Recent Performance Relative to Local Health System Target - WWLHIN	Most Recent Performance Relative to Local Health System Target - Breakdown by Provider							
								CMH	GGH	GMCH	GRH	NWHC	SMGH	WWCCAC	Most Recent Reporting Period
20	Hospital Standardized Mortality Ratio (HSMR)	100	20%	100	80 ↔	TBD	80 ↔	NS	NS	NS	NS	NS	NS	NA	FY 2011/12
21	Readmission Rates for Diabetes (%)	13.56%	-14%	NA	15.45% ↗	TBD	15.45% ↗	NV	NV	NV	15.38%	NV	38.10%	NA	Jan-Mar 2012
22	Readmission Rates for Stroke (%)	6.94%	-38%	NA	9.56% ↗	TBD	9.56% ↗	NV	NV	NV	10.26%	0.00%	0.00%	NA	Jan-Mar 2012
23	Proportion of stroke/transient ischemic attack patients treated on a stroke unit at any time during their inpatient stay	30.2%	45%	87.5%	43.9% ↗	87.5%	43.9% ↗	NS	NS	NS	NS	NS	NS	NS	FY 2010/11
24	Risk-adjusted stroke/transient ischemic attack mortality rate at 30 days (per 100 patients)	12.9	-19%	14.3	15.4 ↔	14.3	15.4 ↔	NS	NS	NS	NS	NS	NS	NS	FY 2010/11

PERFORMANCE KEY:

- Performance is at or below MLPA target
- Performance is off target by up to 10%
- Performance is off target by greater than 10%

TRENDING CRITERIA:

- ↗ Trending up by at least 5% of rolling 12-month performance (if 12 months is available)
- ↔ Trending within 5% up or down of rolling 12-month performance (if 12 months is available)
- ↘ Trending down by at least 5% of rolling 12-month performance (if 12 months is available)

LEGEND:

- **NA** Not Applicable
- **NR** Not Reported
- **NS** Not Stated
- **NV** Volume less than 5
- **TBD** To Be Determined
- * Starting Point: Performance prior to LHIN or first available data point after creation of LHIN

For more information, please visit the Ontario Wait Times Web Site.

LAST REFRESH: January 22, 2013

Appendix: C

Appendix B

Enhancing Your Access to Primary Care	2013-2014		2014-2015		2015-2016	
	Progress	**% Complete**	**Progress**	**% Complete**	**Progress**	**% Complete**
Through Health Links across Waterloo Wellington • Identify and ensure individualized care plans for high system users (top 5%). • Build linkages between health, social services, justice, and other community partners.	In Progress	50	In Progress	75	In Progress	90
Connect more people with a primary care provider, particularly seniors and individuals with complex issues by: • Assessing current primary care capacity throughout Waterloo Wellington and addressing service gaps. • Improving programs such as Health Care Connect to ensure residents who want a primary care provider can get one.	In Progress	50	In Progress	75	In progress	90
Share leading practices to improve availability of same day appointments, after-hours availability, telehomecare and home visits.	In progress	25	In progress	50	In progress	75
Expand the centralized intake process for diabetes services to the remainder of the WWLHIN.	In progress	50	In progress	100		
Identify opportunities to expand successes in diabetes coordination model to support people with other chronic diseases.	Not yet started	25	In progress	50	In progress	75
Develop a Centre of Excellence for eHealth to lead initiatives including: • Increasing the adoption and use of Clinical Connect. • Supporting clinicians to use their Electronic Medical Records (EMRs) to improve quality, access to care and health service planning. • Ensuring primary care providers receive timely information when their patients go to the hospital, and leave the hospital including a discharge summary and list of medications.	In progress	50	In progress	60	In Progress	70

Appendix B

Creating a More Seamless and Coordinated Healthcare Experience	2013-2014		2014-2015		2015-2016	
	Progress	**% Complete**	**Progress**	**% Complete**	**Progress**	**% Complete**
Integrate hospice palliative care services across sectors and providers.	In progress	75	To be completed	100		
Complete the implementation of the Acquired Brain Injury (ABI) integration plan.	In progress to be completed this year	100				
Implement an integrated regional program for Adult Day Programs, including a standardized model of service based on best practice,	In progress to be completed this year	100				
Implement integrations of addictions and mental health services with consideration to the recommendations of the Support Coordination Review, Assertive Community Treatment Teams review and Addictions Services Review.	In progress	50	In progress	60	In progress	75
Implement coordinated access for mental health and addictions services.	In progress	100				
Continue to pursue service and back office integrations to improve client experience, health outcomes and value for money in all sectors.	In Progress	25	In progress	50	In progress	75
Ensure residents get the right care in the community based on the complexity of their needs by defining and adjusting WWCCAC and Community Support Services functions.	In progress	75	In Progress	100		
Improve access to short-stay transitional and respite beds.	In progress	50	In progress	75	In progress	80
Develop opportunities to further enhance the WWLHIN Long-Term Care environments such as through specialized behavioural care.	In progress	25	In progress	50	In progress	75
Identify duplication and streamline system navigation services, freeing up capacity in the system to support more frail elderly.	In progress	25	In progress	50	In progress	75

Appendix B

Leading a Quality Healthcare System Using Evidence-based Practice	2013-2014		2014-2015		2015-2016	
	Progress	**% Complete**	**Progress**	**% Complete**	**Progress**	**% Complete**
Develop a Local Quality Partnership to bring local clinical and system leaders together to improve the quality of local care.	Completed	100				
Improve the quality of services through the roll out of Quality Based Procedures.	In progress	25	In progress	50	In progress	75
Implement the regional integrated program for stroke care which will include the establishment of a dedicated acute stroke unit and specialized rehabilitation services.	In Progress	100				
Complete the next phase of implementation for a regional program for Rehabilitative Care which will include care pathways based on best practices implemented consistently across WWLHIN.	In progress	100				
Implement six new regional clinical programs which will include the establishment of a program sponsor and clinical councils for each program, identification of standards and care pathways and a move towards more equitable access and consistency of quality across Waterloo Wellington: • Addictions/Mental Health • Cardiac • Critical Care with an initial focus on closed access ICUs • Emergency • Pharmacy, starting with anti- microbial stewardship • Surgery , with an initial focus on Quality-Based Procedures (QBPs)	In progress	33	In progress	66	In progress	100
Implement an integrated wound management program across the continuum of care.	Deferred	50		100		
Implement the provincial life or limb policy across Waterloo Wellington.	In progress	100				
Each regional program council will establish standards, monitor key metrics and make system improvements within the program.	In progress	33	In progress	66	In progress	100
The WWLHIN will continue to hold providers accountable through the HSAA for meeting standards set both by the province and locally.	In progress	100	In progress	100	In progress	100

Better Health - Better Futures

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