

2014-2015

Annual Business Plan



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 (connecting and improving) and funding health services to improve the health and well-being of approximately 775,000 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 work with local residents and health care providers to identify and meet the unique health needs of our community. The WWLHIN team is comprised of doctors, nurses, and other health care and business professionals who are dedicated to providing a resident-focused approach to local health care funding, 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.

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

Health Care Vision & Structure



The current health care system includes all of the organizations, programs, services, and people, who work to provide our residents with health care. This includes everything from hospitals, family doctors, and home care workers, to meals on wheels, long-term care, diabetes education, and more. As you can tell, it is a very big and diverse group – there are many people in the system working together to make it better.

The Provincial Vision

The provincial government operates at a 30 or 40-thousand foot level and sets the overarching vision for health care. In 2012, the Ontario Government launched an “Action Plan for Health Care” to build a quality health care system for Ontarians that is more responsive to patient needs and delivers better value for taxpayers. Its three priorities include: keeping Ontario healthy, faster access to stronger family health care, and providing the right care, at the right time, in the right place.

At Street Level

Our Health Service Providers focus on and are experts in their particular areas. Health Service Providers are those organizations that the WWLHIN funds to provide health care. They have a strong understanding of their patients’ needs when they walk through the door. They work at what can be best described as the street level, providing, or ensuring care is provided for our residents.

The Regional System View

Ideally positioned between these two levels, the Waterloo Wellington LHIN has a regional system view. We think about how patients move through and across the health care system, and what they experience while doing so.

Ultimately, we consider both the province’s vision and the work Health Service Providers do on the ground and marry that with the needs of our residents today and projected into the future, as we strive to improve the overall care experience for our local residents.

Why **Local** is so Important

One of the greatest benefits of having a Local Health Integration Network (LHIN) is that we're part of the community we serve. Our residents' health care needs are also ours and those of our friends, family, and neighbours too.

The medical and business professionals who work at the WWLHIN interact with local Health Service Providers on a personal and professional level. The doctors who work at the WWLHIN literally work with us and their patients in the same day. Because we're local, we can readily support providers as they collaborate to make improvements each and every day. When necessary, we intervene to ensure the decisions that are made are in the best interest of residents. We also lead the creation of programs that increase quality and ensure consistent levels of care across the entire health care system. These are improvements that benefit us all.

Most importantly, we interact regularly with the residents who contact our office, and we formally engage our community to get their input and feedback. This Annual Business Plan was built based on the needs and ideas of our residents and Health Service Providers. In fact, it's not just our plan – it's our health care system's plan and together we will deliver on it to improve the health and well-being of residents in our local community.

Our Strategy: One Family's Experience



The best way to explain the WWLHIN's strategy and some of the improvements that have been made already is to look at the experience of one family. This one family's health care needs are representative of thousands of families across Waterloo Wellington.

The Thomas Family lives in Guelph, Ontario. Pam and her husband are separated and she has been supporting her two children Michael, 15, and Sara, 11, on her own. As a single-mom, Pam is focused on the needs of her children. She works two part-time jobs – one as a temporary office worker and one as a cashier at a local grocery store.

She is also caring for her aging father who recently had a stroke. Pam has diabetes, and although she knows she needs to pay more attention to her health, she doesn't have the time.

Michael is an intelligent and caring teenager. He looks out for his little sister and helps his mom how he can. He also struggles with depression and anxiety. His grades have been suffering and Pam has noticed him becoming more and more distant. Michael is very close with his grandfather. After his grandfather's stroke, Michael started using drugs and attempted suicide once. Pam is doing everything she can to get Michael the help he needs.

Sara is a bright light in her family. A bubbly tween, Sara tries to make everyone happy by making jokes, dancing, and singing. School doesn't come easy to her but she tries her hardest. With her family history of diabetes and mental illness, Sara is at a higher risk for developing these illnesses and will need monitoring to keep her healthy and well.

How far we've come

Over the past number of years, great progress has been made locally to improve the health care residents like the Thomas' receive by enhancing quality, implementing integrated programs, and coordinating access to care. But those are complicated terms. What they really mean is that Pam and her children will have a far better health care experience that improves their health and well-being, makes it easier for them to access the health care services they need, and enhances their quality of life.

Because of work done to attract more doctors, open Nurse-Practitioner-led clinics, and expand care provided in family health teams and community health centres (groups of health care professionals in one location who provide family health care) – Pam and her family now have a family doctor, which wasn't the case a few years ago.

Pam and her family doctor spoke about the need to work together to better manage her diabetes. Because of work done to create a single process to refer all patients in Waterloo Wellington for diabetes programs and support – Pam was quickly referred to a diabetes education program and since then her overall health has

improved and she is receiving regular testing. Having a single referral process has reduced the wait time for residents like Pam to receive support and has increased the overall number of residents receiving support.

When Pam's father had a stroke, he was able to receive a life-saving medication in Guelph that wasn't available there before -- his chance of recovery is better because of changes made to improve the quality of care he receives, regardless of where his stroke occurred.

He went home from the hospital sooner than he would have a few years ago because of an increase in the quality and amount of health care available in the home. At home, he was able to receive care from a nurse, personal support worker (a person who helps with daily personal activities such as bathing, dressing, meal preparation, taking medications, bandage changing and more), physiotherapist, and others in his home. Being at home made him happy and comfortable, but it had another benefit – it reduced the amount of time other families waited in the emergency department for their loved one to be placed in a hospital bed.

While the health care the Thomas' received is significantly better than it was five years ago, there are still many more areas where their health could be improved.

Where we are going

When we say our residents are at the heart of our strategy – we mean it.

Let's start with the social determinants of health. We know that there is a connection between income, education, housing, community, and health. These are called the social determinants of health. Pam and her family are at a higher risk of health concerns because they have a lower-income, lower levels of education, and unstable employment. By working with schools, police, communities, and other partners to address the social determinants of health, we are increasingly breaking down silos and changing the conversation from just health care to health. This is vital in the long-term to improve the health of all of our residents like the Thomas'.

Enhancing your access to primary care

We also know that primary care has to be the hub of health care. Primary care refers to all of the health care professionals who provide family health care – this can include a doctor, nurse practitioner, nurse, or even your chiropractor, physiotherapist or social worker. This team forms the basis of care for your general health. Work continues to help all residents who want a primary care provider to find one. Work is also underway to create Health Links across Waterloo Wellington. These Health Links will better connect primary care with hospitals, community support services, addiction and mental health programs, long-term care and more. Through Health Links, residents with very complicated health needs receive special care plans involving multiple care providers to ensure their health needs are being well managed. This means that someone like Michael who needs treatment for multiple health concerns can receive better care through a team approach that connects him with all of the right people. This can include traditional health care providers, but also contacts in the education sector, crime prevention, and more. This way we are addressing all of the social determinants of health, not just those that are health care based.



Better coordinating your care

If primary care doctors, nurses and others are going to effectively manage care for Pam and her family, they need easy access to a range of services. That's where coordinated access comes in. Michael needs help for both his substance abuse and his depression, and his primary care team needs an easy way to provide that for him. Work is underway to develop "one front door" for addictions and mental health care, meaning there is one number to call and Michael will receive all of the care he needs. It also means that no matter where Michael is sent for care – it's the right place and he won't be turned away.



More work will be done this year to expand this program to include care for all chronic diseases. Chronic diseases are those requiring long-term treatment such as heart disease, respiratory illnesses, and diabetes. One number and one front-door means shorter wait times, and easier access for more residents.

Improving the quality of the care you receive

We talk a lot about improving quality - but what does quality actually mean? Quality health care means that the care you receive is: safe, effective, accessible, equitable, efficient, sensitive to your needs, integrated, appropriately resourced, and focused on preventing illness as much as treating illness.

One way we improve quality is by connecting programs and services through what is officially termed integration. Integration is about ensuring the same standard of care is provided in all locations, and improving the patient experience. This way, no matter where a family lives, or who they are, they will receive the same quality of care. Integration also increases efficiency, freeing up resources that can be reinvested into other programs.

As technology changes and new research comes out we are constantly evaluating how we can do better for our residents. This year, work is being done to expand the use of technology like telemedicine (visiting a specialty health care provider through a video conference so you don't have to travel) and the use of electronic medical records so your doctors all have access to your health care history at their fingertips on a computer. This way the Thomas' family doctor can easily track their care, access reports and tests from other health care providers, and improve the care he provides to the whole family. This also improves safety and efficiency by reducing the need for repeat tests, reducing the amount of time it takes to get information, and more.

The Plan

As the Thomas' experience illustrates, improvements have been made in our health care system, but there is much work still to do. The rest of this *Annual Business Plan* outlines the priorities for the coming year as we continue along a roadmap that was set out in the government approved *Integrated Health Service Plan – Better Health, Better Futures* (2013 – 2016). This *Annual Business Plan* will serve as a guide for our staff, and our Health Service Providers, for how we will work to improve health care for our residents over the next year.

In this document you can read about initiatives in key areas, as well as information on principles, objectives, and priorities that guide our work. We often bucket the work we are doing to improve health care into different categories – such as improving quality or enhancing access to primary care. And as you'll see if you continue reading, we tend to use formal language and lots of jargon in our formal plan. This is because the information can be complex and the people dedicated to implementing it are trained experts in a range of different medical

and business professions. If you don't understand something, we are always here to explain it to you. This is your health care system and your plan as much as it is ours.

The truth is formal language and buckets aside – it is all connected. Overall, our work over the next year is focused on the specific health needs of Pam and her family – and the thousands and thousands of other families with their own unique health care needs across Waterloo Wellington.

Guiding our Plan

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 health care 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.

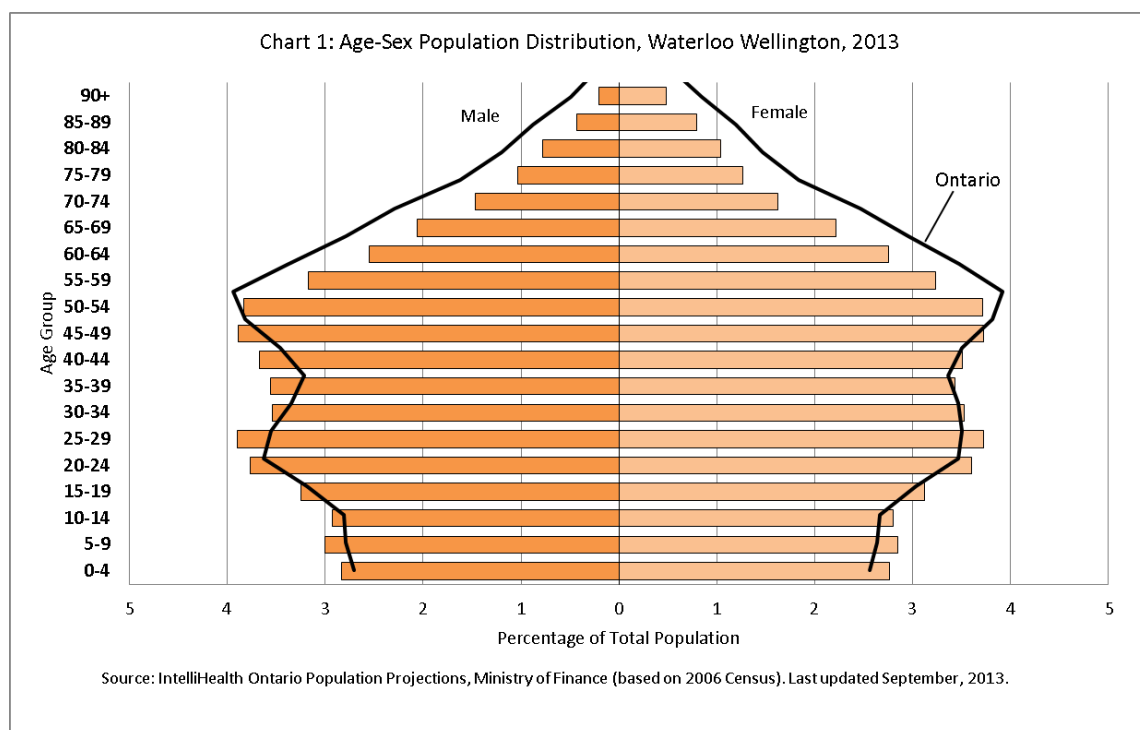
Principle #2: Focus on the top 1-10% of health care users who utilize most of the health care resources – people with complex health and social care need.

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

Our Community

Population Snapshot

The Waterloo Wellington Local Health Integration Network is home to over 775,000 residents, 5.7% of the population in Ontario. Our population continues to grow at a rate of about 1.2% each year, which is slightly faster than the province as a whole. Approximately 11% of our residents live in rural areas. The WWLHIN has a relatively young population with 87% of residents under the age of 65 years (See Chart 1 for population pyramid comparing Waterloo Wellington to the province). There are approximately 104,000 residents who are over the age of 65 years.



There are approximately 10,500 residents who include French as their first language and over 15,000 who have knowledge of French and speak French at home (this includes many recent immigrants). Over 20% of the population in Waterloo Wellington are immigrants, while almost 14% are visible minorities; these population proportions are lower than what is experienced provincially.

There are over 10,000 Aboriginal residents in the WWLHIN, representing 1.2% of the total population. Aboriginal residents in the WW LHIN have lower education and income levels, and higher unemployment levels compared to the rest of the WWLHIN. Additionally, estimated rates of asthma, diabetes and chronic bronchitis are about twice as high for Aboriginal residents compared to the total population in the LHIN.

The average life expectancy for WWLHIN residents is 82 years of age. Self-reported health, an indicator of overall health status, can reflect aspects of health not captured in other measures, such as disease severity,

aspects of positive health status, physiological, social and mental function. Waterloo residents are more likely to rate their health status as very good or excellent than others in Ontario.

Poor health practices are correlated with an increased risk of chronic conditions, disability and death. Roughly 17% of residents are daily smokers, while over half of the adult population is overweight or obese and almost 60% of residents report they consume less than 5 servings of fruits and vegetables daily.

Both the unemployment and low income rates in Waterloo Wellington are lower than provincial rates. Approximately 58% of residents have completed post-secondary training, with a highest attainment in the Guelph region (62.4%) and the lowest in Rural Wellington (50%). There are almost 50,000 residents in Waterloo Wellington who are living below the low-income cut-off, representing 7.2% of the WWLHIN's population.

Key Drivers

In the last year, we have been very successful in connecting more people in our region with a primary care provider. There has been an increase in the number of primary care providers in the region, including those whose practice is dedicated to caring for residents who may have vulnerabilities or complex medical conditions. The Health Links initiative has enabled providers to take on more of the high needs complex residents in our region to ensure they have a primary care provider to manage their health needs. Additionally, having a local site for medical training has enabled more physicians to train locally, which has resulted in more new graduate physicians choosing to practice in the Waterloo Wellington region.

Creating equitable and accessible access to health care solutions is a key priority for our residents. With our providers and greater community, we are working to provide wrap-around care for those residents with the highest needs. Many of these high needs residents are vulnerable and have difficulty managing what are complicated system transitions that can lead to these residents slipping through the cracks. Identifying the high needs residents and developing wrap-around care that not only includes health care providers, but also the broader community, will coordinate care for these residents to ensure they receive appropriate care and are able to effectively manage their health needs. We anticipate that there will be approximately 500 residents with wrap-around care plans by the end of 2013-2014 and we will continue this work across the LHIN in the coming year.

Mental Health and Addictions and Chronic Disease Prevention and Management (CDPM) are key drivers to our system plan in providing appropriate, accessible and equitable care for residents in need. The WWLHIN seniors population increased by 4.3% between 2012 and 2013, which is a slightly higher growth rate than the province. As the population ages, having effective CDPM programs that are accessible to our population is important to enable residents to prevent and manage chronic conditions. Through engagement with providers and expert panels, we know that we can improve the coordination and accessibility of mental health services in our region.

We have heard from providers that there are gaps in program utilization and access for many areas of care including mental health services, chronic disease prevention and management, rehabilitation services and medical specialists. The WWLHIN, in collaboration with our providers and partners, is working to develop a coordinated access system that will be available to providers and residents to easily access the appropriate care at the right time.

We will continue working with our providers to implement provincial and local strategies that will improve patient transitions and information sharing. Progress was made over the past year to increase sharing of patient information, but this work must continue to ensure that appropriate follow-up care can be provided when necessary and to decrease the need for the resident to tell their story more than once.

Strategic Priorities for our Local Healthcare System





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 health care 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 health care 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 health care 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 health care professionals to make the best health decisions in developing health care 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 health care as the hub of the health care system to improve your access to services and positive health outcomes.

- Establish individualized, coordinated care plans for high needs residents through Health Links across Waterloo Wellington.
- Build partnerships between health, social services, education, justice, and other community partners to improve population health.

Improve timely access to primary care.

- Improve health equity through improved access to care close to home.

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

- Improve access and implement best practice guidelines for diabetes care and chronic disease prevention and management in Waterloo Wellington.

Improve timely information sharing between primary care and other providers.

- Implement enabling technologies including:
 - o Ontario Laboratory Information System (OLIS)
 - o Hospital Report Manager (HRM)
 - o Technology supporting Health Links.

Expected outcomes for Waterloo Wellington Residents:

- High needs residents will have individualized coordinated care plans developed through a Health Link in Waterloo Wellington – Target: 2,400 care plans
- All Complex Patients within a Health Link will have a Primary Care Provider
- Fewer residents will have to be readmitted to hospital for chronic conditions– Target: 14% rate of readmissions.
- Fewer residents will be hospitalized for chronic medical conditions that can be treated effectively in community – Target: 20% Reduction

Potential risks/barriers to successful implementation of the initiatives:

- Health Links are an improved way to deliver existing service in a collaborative, coordinated way and not a new “program”. 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’ services but is still within sphere of influence.
- The success of a 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 model 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.
- Improving the health of the population and improving rates and management of chronic diseases will see results over the mid- to longer- term and will require commitment and patience to experience the results.
- Implementing enabling technologies is dependent on numerous stakeholders provincially and locally. Timelines may be negatively impacted due to numerous external factors.

Key enablers to achieve outcomes:

- Health Links will be an important structure to advance improvements in care for our residents with complex health needs including seniors and others with complex conditions.
- Continued support from the Ministry of Health and Long-Term Care to remove barriers will allow our local team to build more links across the health system. 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 are examples of provincial efforts guiding and supporting local efforts.
- Electronic sharing of clinical information will 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' will assist health system managers in deploying effective services focused on local needs.
- WWLHIN Primary Care Physician Lead, Chronic Disease Prevention & Management Physician Lead and eHealth Physician Lead will 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.
- The all-of-community approach to addressing the social determinants of health and Chronic Disease Prevention and Management will improve health outcomes for residents.



Our Priority: Creating a More Seamless and Coordinated Health Care 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 health care 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 health care system is especially difficult for those with the most complex needs. Approximately 1% of those residents who accessed our local health care services in 2009-2010 (1,400 residents) accounted for upwards of 20% (\$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 5% of total health system users accounted for almost \$330M in total health care costs. This 5% 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 Ontarians 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 health care 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 2008-2009 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 health care 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).

- Expand and improve upon streamlined, coordinated access to services across the continuum of care.
- Strengthen and maximize the current quality & capacity of community services.
- Remove barriers for people waiting for an Alternate Level of Care.
- Improve care for seniors through implementing key recommendations of the Provincial Seniors Strategy.
- Improve the quality and safety of care in Long-Term Care Homes.

Expected outcomes for Waterloo Wellington Residents:

- Residents will have more connections to health care services through coordinated access centres
- Following service authorization, residents will wait no more than 5 days for in-home nursing and personal support worker service.
- Residents will spend fewer days in hospital when they should be receiving their care in a more appropriate location
- Residents will experience timely access to long-term care assessments

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 need to adapt to support the level of acuity 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.
- Coordinated access efforts must ensure that these services streamline and improve access to care and not add unnecessary steps or confusion.
- Design based on resident experience may challenge current ways of providing service and require openness to and implementation of significant change.

Key enablers to achieve outcomes:

- Health Service Provider boards considering the system perspective including better health, better care, and better value for residents will assist in identifying and prioritizing system integration initiatives.
- Standardization of reporting practices and business tools used within and across sectors will assist in streamlining through coordinated access.
- Existing collaborative Networks and Councils will be keys to assess and drive out change in the system.
- Identification of duplication and streamlining services will free up capacity to provide more services to residents.



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

The nature of health care 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 health care services using an integrated clinical program model. An integrated clinical program is a single standard of care that is based on best practice evidence for specific patient groups. An integrated clinical 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 an integrated clinical program 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 integrated clinical 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 health care 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 WW 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:

- Improve patient outcomes through the delivery of best practice care, at the best practice price, in alignment with province-wide Quality Based Procedures.
- Expand and enhance integrated programs that ensure quality and deliver best practice care across the continuum of care. Key improvements will include.
 - Cardiac:
 - i. Identify and implement improvements including remote pace-maker monitoring trial.
 - Critical Care
 - i. Implement the provincial life or limb policy across Waterloo Wellington
 - ii. Implement critical care High Performing Checklist
 - Emergency Department
 - i. Implement best practices across the continuum of care to meet emergency department wait times
 - ii. Implement standardized care pathways (beginning with asthma & influenza)
 - iii. Implement best practices for patient triage.
 - Hospice Palliative Care:
 - i. Improve admission process.
 - ii. Improve service delivery model to support clients at home..
 - Mental Health and Addictions
 - i. Develop and implement service improvements based on the experience of high needs residents
 - ii. Improve youth addictions services
 - iii. Improve access to more effective mental health services for youth and young adults.
 - Rehabilitative Care
 - i. Implement standardized patient pathways across sites.
 - Surgery
 - i. Design and implement an integrated access system for orthopedic surgery.
 - ii. Develop and implement the Waterloo Wellington Vision Plan including possible community-based specialty clinics.
- Implement new integrated 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:
 - Integrated Diagnostic Imaging Program.
 - Integrated Wound Program.

Expected outcomes for Waterloo Wellington Residents:

- Residents will receive non-urgent Cardiac By-pass Surgery within 84 days
- Residents with a life or limb threatening condition will be transferred to an appropriate facility within 4 hours or less
- Patients requiring admission from the emergency department will be transferred to a hospital bed in 8 hours or less
- Patients with complex needs requiring care in an emergency department will be seen and sent home in 7 hours or less
- Patients with minor, uncomplicated needs requiring care in an emergency department will be seen and sent home in 4 hours or less
- Residents will have the ability to die at home or within a community setting rather than in hospital
- Fewer residents will have repeat visits to the emergency department for Mental Health Conditions
- Fewer residents will have repeat visits to the emergency department for Substance Abuse
- Residents will receive non-urgent hip replacements within 26 weeks
- Residents will receive non-urgent knee replacements within 26 weeks
- Residents will receive non-urgent cancer surgery within 12 weeks
- Residents will receive non-urgent cataract surgery within 26 weeks
- Residents will obtain non-urgent MRIs within the 4 weeks
- Residents will obtain non-urgent CT scans within 4 weeks.

Potential risks/barriers to successful implementation of the initiatives:

- Health System Funding Reform poses risks, both positive and negative, to system integration with sometimes limited understanding of how the funding will change as a result of local system changes.
- Stakeholder support and leadership is needed 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).

Key enablers to achieve outcomes:

- Quality Based Procedures and the related quality expectations are important drivers to quality improvements and the health and well-being of residents.
- 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, will continue to evolve and support better care, better health, and better value.
- Collaboration through Integrated Programs including providers across the continuum of care and engaging patients/residents in the system change will improve the residents' experience and health outcomes.
- Data developed through centralized resources such as Cardiac Care Network, CritiCall Ontario, and others support the Integrated Councils in understanding the local service landscape and priorities for system improvement.
- Collaborating with local post-secondary institutions, such as Conestoga College, will assist with improving quality of care now and into the future.



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 four 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 French-speaking and Aboriginal Communities.

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 French-speaking and Aboriginal residents, are considered as new solutions are put into place.

French Language Service Plan

The French-speaking community of Waterloo Wellington includes an increasingly culturally diverse population as new immigrants make up the majority of new French-speaking people in our region. Specific data on the increase of French-speaking residents in our area is not readily available since the last census did not use the Ontario's definition of French-speaking; however, across Ontario, the French-speaking population increased 6% over the 2006 available data. Most recent data suggest that there are approximately 10,500 residents who include French as their first language and over 15,000 who have knowledge of French and speak French at home (this includes many recent immigrants).

The WWLHIN, in line with its core value of acting in the best interest of our residents' health and well-being, has implemented a number of French services within the system such as mental health services via telemedicine, French speaking primary care through the establishment of a bilingual family health team, palliative care counseling in French and enhanced French-speaking community services through the Waterloo Wellington Community Care Access Centre.

Over the last year, with the support of the comprehensive 'Community-based Participatory Survey on the Health Status of the French-speaking of HNHB and Waterloo Wellington' done by our region's French Language Service Planning Entity (Entité²) alongside the results of the WWLHIN's survey, we have been able to identify and prioritize many of the health care needs of our French speaking community.

While all of the initiatives outlined in this *Annual Business Plan* apply to all residents, including French-speaking residents, we will continue to implement and initiate new activities that will improve services specifically for French-speaking residents. Our Action Plan for 2014-2015 includes:

- Continue to monitor, assist and support existing French language services program initiatives in WWLHIN such as: a) mental health telemedicine program; b) access to primary care through the existing multilingual Family Health Team and c) palliative care counseling that offers services in French to WWLHIN residents.
- Ensure that French language services are part of any new initiatives such as Chronic Diseases Prevention and Management to address the higher rate of chronic diseases among the French-speaking community.
- In partnership with Health Service Providers, implement community services to support French-speaking seniors in Waterloo Wellington.
- Work in partnership with other agencies and ministries to support and complement services being offered by each sector such as education, children and youths services, and public health.
- Work collaboratively with the French Language Planning Entity in local planning.

Aboriginal Service Plan

The Aboriginal residents of Waterloo Wellington include a culturally diverse community of approximately 10,185 people, according to the National Household Survey 2011, and the majority of these individuals reside in urban centres across the region. Local experts within the community tell us that the number is much higher as many within the community do not identify themselves as Aboriginal.

Ontario's Aboriginal population is relatively young, growing rapidly and culturally diverse including persons who identify as First Nations, Métis and Inuit. According to available data, the Aboriginal population as a whole has poorer health status than other demographic groups. As a population, Aboriginal peoples experience: shorter life expectancy and higher infant mortality; greater prevalence of mental health issues, addictions and Fetal Alcohol Spectrum Disorder; and higher rates of chronic and infectious diseases.

As the WWLHIN continues to implement its strategic direction of acting in the best interest of the residents, we will build upon efforts initiated over the past year to develop collaborative opportunities with the Aboriginal community to better identify opportunities to improve their health. Given the strong relationship between the social determinants of health and the health status of the Aboriginal community, we must ensure the participation of other sectors service providers to maximize the results.

The previous needs assessments completed with our Aboriginal residents identified a need to prioritize their health care needs and develop a plan for action. The WWLHIN has funded the Kitchener Downtown Community Health Centre (KDCHC) to work with the Aboriginal community and develop an Aboriginal Plan for the LHIN. The KDCHC has established a Health and Wellness Program Circle with various Aboriginal leaders and stakeholders that will serve as an advisory council and guide the development of our region's Aboriginal Plan. The Plan will build on previously identified priorities including: access to primary care to address the rate of chronic diseases; mental health and addiction services in partnership with existing service providers; and palliative care through building on the already existing services for this community. It is imperative that we, as the planning and funding organization, ensure that all Health Service Providers develop equitable programs and services that are offered using culturally appropriate approaches for the Aboriginal community and based on the recommendations from the Health and Wellness Aboriginals Program Circle.

As we progress in the development and implementation of health services that are appropriate for our Aboriginal community, we have to consider not only the needs of this community, but also the cultural background and long history of mistrust and lack of empowerment that that our Aboriginal peoples have endured. To address those issues, a comprehensive cultural safety and competency program was delivered to all Health Service Providers, as well as the Board members, and staff of the Waterloo Wellington LHIN.

WWLHIN Operations

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 2014-2015:

- 36 FTEs.
- Total Employee Benefits as 20% of Salaries and Wages.
- Total Governance Costs are flat from the 2012-2013 allocation.
- Sustained expense reductions for LSSO and LHINC implemented in 2012-2013

WWLHIN Operating Budget

WWLHIN Operating Budget for Fiscal Year 2014/2015

	2014/2015 Budget	2013/14 Forecast (Jan 2014)	2013/2014 Budget	2015/2016 Forecast	2016/2017 Forecast
REVENUE					
Operating	4,198,719	4,180,719	4,198,719	4,198,719	4,198,719
Diabetes RCC	1,057,284	1,057,284	1,057,284	1,057,284	1,057,284
Total Base Revenue	5,256,003	5,238,003	5,256,003	5,256,003	5,256,003
Aboriginal Planning	5,000	5,000	5,000	5,000	5,000
Diabetes RCC one-time	-	140,000	284,000		
eHealth Ontario	510,000	280,000	-	510,000	510,000
French Language Health Services	106,000	106,000	106,000	106,000	106,000
ED Lead	75,000	75,000	75,000	75,000	75,000
Critical Care Lead	75,000	75,000	75,000	75,000	75,000
Primary Care Lead	75,000	75,000	75,000	75,000	75,000
ED/ALC Lead	100,000	100,000	100,000	100,000	100,000
Total One-Time Revenue	946,000	856,000	720,000	946,000	946,000
TOTAL REVENUE	6,202,003	6,094,003	5,976,003	6,202,003	6,202,003
EXPENSES					
Salaries & Benefits	4,814,943	4,409,942	4,466,868	4,911,242	4,950,000
Salaries, Wages, Benefits	4,814,943	4,409,942	4,466,868	4,911,242	4,950,000
Communications & Comm Engt	65,600	78,372	65,600	65,600	65,600
Consulting Services	150,000	266,070	150,000	62,554	50,000
Supplies	57,333	67,403	57,333	58,480	59,650
Mail, Courier, Telecomm	40,000	43,489	60,000	40,000	40,000
Travel	40,000	28,404	44,000	30,000	30,000
Printing & Translation	45,000	22,694	47,575	45,000	45,000
Training & Development	59,000	161,225	59,500	59,000	45,000
Computer Equipment	49,303	88,312	49,303	49,303	35,929
Direct Operating Costs	506,236	755,969	533,311	409,937	371,179
Occupancy	324,719	332,125	404,719	324,719	324,719
Shared Services	341,620	401,664	356,620	341,620	341,620
LHIN Collaborative	47,500	47,500	47,500	47,500	47,500
Other Fixed Costs	713,839	781,289	808,839	713,839	713,839
Board Chair Per Diems	72,800	64,070	72,800	72,800	72,800
Board Per Diems	48,250	44,670	48,250	48,250	48,250
Board Travel	8,750	10,373	8,750	8,750	8,750
Other Governance Costs	37,185	27,690	37,185	37,185	37,185
Governance Costs	166,985	146,803	166,985	166,985	166,985
TOTAL EXPENSES	6,202,003	6,094,003	5,976,003	6,202,003	6,202,003
TOTAL SURPLUS/(DEFICIT)	0	0	0	0	0

FTE Count

36

33

Communications & Community Engagement Plan

Background/Context:

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 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: improving access to care; improving coordination and integration of care; and improving quality of care. A number of system improvement initiatives have been identified within each of the three priorities.

Obsessively patient and resident-centred

The Waterloo Wellington LHIN (WWLHIN) is driven by acting in the best interest of the health and well-being of its residents. Aligned with Ontario's Action Plan for Health Care, our Integrated Health Service Plan and Annual Business Plan are "obsessively patient-centred." The WWLHIN puts residents first in every discussion and every decision. This requires a comprehensive understanding of the needs of local residents and the development of local solutions to best meet those needs. The WWLHIN accomplishes this through communication and community engagement with residents and key stakeholders.

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

Just as the WWLHIN needs to understand its residents, it is important that residents and other stakeholders understand the role and work of the organization charged with transforming the system. In the past there have been low levels of understanding. For instance, a 2012

survey conducted by Ipsos Reid reported that two-thirds of Waterloo Wellington residents said they had never heard of the WWLHIN, while just over one-in-ten said that they were at least somewhat familiar with the organization.

As significant efforts are made to improve the health care system for local residents, it is becoming increasingly important to build support from residents as well as others involved in impacting the social determinants of health. Increasing awareness of the WWLHIN and its work will assist the Network and its health service providers in making the necessary changes to build a high-quality, integrated, and sustainable health care system. It will also ensure the LHIN is in a position to help residents and others better understand the system they must navigate.

Clarity, alignment and resident-friendly language

From a communications perspective, great strides have been made in using public-friendly language, and ensuring clarity and alignment in communications with our residents, our health service providers, and our other partners.

This integrated communication and engagement plan significantly advances this approach. It also focuses on initiatives that will reach strategic target audiences to spread provincial and local LHIN key messages, enhance

awareness and understanding of both the WWLHIN and the system, and contribute towards the achievement of the ABP initiatives.

Objectives:

Through this communications and community engagement plan, the WWLHIN seeks to inform, educate, consult, involve, collaborate with, and empower its various stakeholders. The WWLHIN needs to have a clear understanding of the priorities and wishes of the communities it serves. The WWLHIN also requires its stakeholders to have a good understanding of its role, the need for change in the health care system, and the progress that has been made to date.

These objectives are well aligned with the Ministry of Health and Long-Term Care's goal to build a health care system around the needs of our patients and communities. Increasing awareness and input from stakeholders will help keep residents healthier, increase access to care, and help residents receive the right care, at the right place, at the right time.

- To increase awareness and understanding of the WWLHIN's role - leading a high quality, integrated health system for its residents.
- To engage residents and other stakeholders in identifying the changes needed in the health system.
- To prepare residents for upcoming changes to the way health care services are organized and delivered to improve quality of care. To highlight past and current achievements to promote progress, at the same time building understanding of the future changes needed to improve care for residents.

Target Audiences:

As the WWLHIN focuses on meeting the needs of its residents, input and support from a variety of stakeholders is needed. The WWLHIN's diverse stakeholders have different understandings of the health care system and the role of the LHIN in planning, integrating and funding the system. The WWLHIN has identified the following stakeholder groups as key.

- **Local Residents** (with a focus on diversity and accessibility, including Aboriginal and Francophone residents)
- **Our Local Health Care System Providers**
 - o Boards of hospitals, community service agencies, community health centres, Community Care Access Centre, mental health and addictions agencies and long-term care homes
 - o Physicians, nurses, other clinicians and staff
 - o Administrators of hospitals, community service agencies, community health centres, Community Care Access Centre, mental health and addictions agencies and long-term care homes
 - o

- ***Organizations that influence the health and well-being of our residents and the social determinants of health***
 - o Municipalities
 - o Public Health
 - o School Boards
 - o Private Sector
 - o Ministry of Health and Long-Term Care
 - o Others

- ***Internal to the Waterloo Wellington LHIN***
 - o LHIN Board of Directors
 - o LHIN Staff

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

- ***Other External Stakeholders***
 - o Government Relations
 - o Media

Key Messages:

Transformational Messaging

Ontario is shifting the focus of its health care system to revolve around the person. We have a plan to ensure Ontarians have access to high quality care and a sustainable health system for years to come. By organizing our system differently and focusing on the medical evidence, we will provide Ontarians with better care and better value for tax dollars.

Through these changes, we expect to see:

- Reduced wait times and faster access to family doctors
- Fewer unnecessary visits to the emergency room and re-admissions to hospital
- Patients receiving care at home or in the community instead of in a hospital

How are we transforming the health care system?

- Partnering with the sector and enabling them to play an active role in how the system will change.
- Strengthening community agencies to support providers and encourage integration around the patient's needs.
- Health care funding will be determined based on the best evidence and will follow the patient.

What can we expect from these changes to the healthcare system?

- A system built for patients by the health care providers and leaders closest to them.
- A health care system that integrates providers around patients to deliver better outcomes.

Pan-LHIN Key Messages

- *Making the System Work More Like a System* - LHINs are building a better health care system for clients and patients by challenging traditional silos and barriers between health service providers.
- *Ensuring Value for Money* - LHINs are holding health service providers more accountable for the services they deliver and for the public dollars entrusted to them.
- *Improving Access to Care* - LHINs are working with local health service providers to improve access and enhance the experience of patient and clients.
- *Taking a Population Perspective and Promoting Equity* - LHINs are committed to health equity to ensure that every individual, regardless of gender, race, income or social status, has the same access to high-quality health care.

WWLHIN Key Messages

- 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 is generating 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.
 - o 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.
 - o 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.

- o 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.
 - o 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.
- 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.
- While individual health service providers are focused on their own organizations and mandates, the WWLHIN looks at the entire system and identifies opportunities as well as needs and challenges.
- To achieve its mandate, the WWLHIN:
 - brings providers together to better connect health services
 - makes investments and funding decisions based on the needs of our residents,
 - leads the creation of programs,
 - introduces measurements and targets, and holds health service providers accountable through service accountability agreements,
 - when necessary, intervenes to ensure the decisions being made are in the best interest of the residents.

Achievements

- Since the start of the WWLHIN, local residents are waiting up to 80% less time for surgeries.

- The most recent data shows that hospitals in Waterloo Wellington recorded the lowest emergency department lengths of stay for admitted patients ever recorded in Ontario.
- Local residents are now able to access diagnostic services up to 80% faster than before the WWLHIN.
 - ✓ Reducing wait times for a non-emergency MRI from 224 days to 56 days – a 75% improvement
 - ✓ Reducing wait times for a non-emergency CT from 132 days to 27 days – an 80% improvement
- More residents are receiving the right care, in the right place, at the right time. When the WWLHIN started, more than 20% of hospital bed days were occupied by patients who were waiting for care in other settings (Alternate Level of Care). Now only 12% of those bed days are occupied by these patients.
- More than residents now have access to a primary care provider. More than 14,000 residents, 90% of those who registered for health care connect, have been matched with a primary care provider.
- Through the Network's leadership, care has been successfully integrated for vascular services, cardiac care, bariatric services, children's addictions services, inpatient mental health, stroke care, and more. Plans are underway to integrate community support services, community mental health and addictions, rehabilitation and hospital care in Waterloo Wellington.

Tactics:

The WWLHIN will continue to engage its residents and stakeholders in a variety of formal and informal ways. We speak with our residents and stakeholders every day. This has great impact on the work of the WWLHIN and actively informs its decision-making process. The WWLHIN will utilize existing channels (ex. networks/councils/website) and seek to develop new channels to proactively engage and communicate with stakeholders.

Specific effort will also be taken to engage the WWLHIN's diverse residents, including its Aboriginal and Francophone communities. The WWLHIN works with the Waterloo Wellington Hamilton Niagara French Language Health Planning Entity to identify the specific health care needs and priorities of francophone residents. The WWLHIN also makes a number of its communications documents available in both official languages. As the WWLHIN undertakes a review and restructuring of its website, emphasis will be placed on adding bilingual content and improving accessibility for residents with disabilities. The WWLHIN is also working to increase accessibility by holding events in

accessible locations and providing a variety of mediums for communications. The WWLHIN communicates and engages with local Aboriginal residents through a number of organizations that specialize in serving this population. Additional work will be done to identify additional opportunities for communicating and engaging with Aboriginal residents. More detail is provided in the ABP under the priority of creating a more seamless and coordinated health care experience.

The following chart details analysis of the WWLHIN's target stakeholders, as well as the various communications and community engagement tactics that will be utilized to reach the objectives in this plan.

The WWLHIN will further refine its communications and engagement plan on an ongoing basis to ensure the right stakeholders are engaged, and to maximize the plan's impact, within available resources.

Stakeholder Group	Analysis	Communications	Community Engagement
Residents	• Low to Moderate (Mod) interest • Med influence • Uninformed/negative position • Potential endorsers • Educate/Inform/Consult	Newsletters Social Media Website Videos Community Report	Surveys Community Council Resident Input/Concern Tracking
Health Care Service Providers	• High interest • High influence • Positive and negative position • Potential endorsers • Involve/Collaborate	Newsletters Social Media Website Videos	Surveys Special Events Presentations Attending board meetings, events, meetings, etc.
Influencing Organizations	• Low to Mod interest • Mod influence • Positive/Negative/Uninformed • Educate/Inform/Consult	Newsletters Social Media Website Videos	Presentations/Fee dback Sessions Leader/Leader and Board/Board meetings
Internal	• High interest • High influence • Positive position • Collaborate/Empower	Sharepoint Intranet Board Meetings Daily Articles of Interest Sharing of News/Info/Issues	Staff Meetings Board and Committee Meetings Staff and Board Surveys
Advisory Groups/Networks	• High interest • High influence • Positive and negative position • Potential endorsers • Involve/Collaborate/Empower	Newsletters Website Videos Meetings with Chairs	Network Meetings Engagement sessions
External (Government Relations/Media)	• Mod interest • Med influence • Positive and negative position • Educate/Inform/Consult	Newsletters News Releases Targeted Pitches	Meetings/Presentations with Government stakeholders News Conferences

Evaluation:

Evaluation is crucial to determine the success of the WWLHIN's communications and community engagement initiatives. The WWLHIN intends to conduct benchmark research as a means of evaluating current levels of awareness and resident/patient priorities. This will also serve as a catalyst for the development of new initiatives to better engage target audiences. Current evaluation tools include:

- Google and Web analytics
- Community engagement tracking
- Surveys
- Social media monitoring tools (Facebook insights, TweetReach, Bitly, You Tube analytics)
- Traditional media monitoring

Communications and community engagement engagements will be measured through: baseline and subsequent survey results, participation rates in community engagement activities, quantity and quality of communication outputs and media reporting.

Note: The Ministry of Health and Long-Term care has invested additional funding in the WWLHIN for specific projects and the engagement of specific stakeholders. The WWLHIN integrates the engagement for these initiatives into its overall annual community engagement plan.

APPENDIX: A

Strategy Update

2013 – 2014 Annual Business Plan Progress

Report to the WWLHIN Board of Directors - January 30, 2014

Grounded by the Mission,

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

We are committed to achieving the vision for the health care system:

Better Health – Better Futures

With a strong foundation established in 2013/14 that set out clear strategic priorities for the local health care system in Waterloo Wellington, we have been making strides towards achieving better health, better care, better value.



Enhancing Your Access to Primary Care

Health Links in Waterloo Wellington

The role of Health Links is to bring together all types of providers to develop resident focused care for individuals who have multiple or/and complex needs. Health Links is not a new service but rather a more effective use of existing resources. In order to be successful, Health Links requires strong engagement from Primary Care so that they can be better linked to the system. The WWLHIN geography has been divided into four Health Links, which are at various stages of development. The first step is the development and submission of a Readiness Assessment to the LHIN and the Ministry of Health and Long Term Care. Once the Readiness Assessment has been approved by both parties, the Health Link is then asked to complete a Business Plan. The Business Plan again requires the approval of the LHIN and the Ministry. With this second approval, the Health Link moves forward with the implementation of the Business Plan.

As part of the development of Business Plan, the Health Links are measured according to three levels of metrics 1) Operational Metrics (e.g. number of care plans, increase number of individuals linked to primary; 2) Results-Based Metrics (e.g. reduced readmit to hospitals; reduce time from referral to home care visits, etc.); and Evaluation-Based Metrics (e.g. enhanced patient experience, etc.)

Through the Health Link conversations and with the ongoing modification of the CCAC Client Care Model, providers continue to define and identify the 1-10% of the population who are the high users of the system. They better understand the unique needs of that population group, and that a one-size fits all solution is not in the best interest of the residents. This has been a learning curve by all providers. As the patient experience has been examined, it became apparent that each resident has unique needs that may not be able to be addressed by one care provider and requires strong communication between a number of providers to ensure that residents are supported in their home as safely, effectively and appropriately as possible.

Guelph Health Link

Guelph Health Link's Business Case was approved in June 2013. There are now 200¹ people served by the Guelph Health Link who have a care plan in place, and the team is continuing to identify additional individuals who would be suitable to be a Health Link member. Guelph is a leader in the province for the number of care plans and they are actively contributing to provincial initiatives such as the development of a common coordinated care plan tool. The Health Link is confident that there will be 500 care plans in place by March 31, 2014.

The early part of the work was identifying a number of complex individuals and outlining the process involved (e.g. interview process, development of care plan, etc.). They spent time reducing duplication at intake, assessment and service provision. Given this upfront work, they feel they can more quickly move to implementation and monitoring of care plans for the next cohort of identified complex individuals.

Looking forward to the end of this fiscal year and into 2014/15, the Guelph Health Link will be developing ways to expand the basis for identifying clients, improve the coordinated care planning process, and they are also beginning to reach out to new partners in the community. In addition, it will be important for this Health Link, and the others as they begin their work, to look at how care plans can truly make a difference for people from service, quality and experience perspectives.

Rural Wellington Health Link

The Rural Wellington Health Link was approved to move to Business Case development in October 2013. The Steering Committee has been working hard and the Business Case will be ready for submission to the LHIN and MOHLTC in January 2014. The Business Case provides details on establishing a system-level team focused on improving the patient experience and enhancing self-management capacity. The partners are excited to begin the work of embedding a culture that meets the needs of people who have multiple or complex needs in a coordinated way through the creation of care plan development.

This Health Link had worked hard to understand their population by looking at the unique aspects of caring for people in rural communities. For example, these individuals tend to be more isolated, have less stable incomes, and have higher than average rates of chronic disease. The development of the Rural Wellington Health Link also contributes to achieving the vision of the "Rural Health Integration Report."

Kitchener Waterloo Wellesley, Wilmot & Woolwich (KW4) Health Link

While waiting for the approval of the Readiness Assessment from the province, the KW4 Health Link has already established their Steering Committee. The Steering Committee has membership from physicians and other care providers (representing a variety of primary care settings and models), community partners, and regional representatives (e.g. EMS, Housing). A particular focus area for the KW4 Health Link is to demonstrate

¹ The number of care plans is an updated amount as of January 13th in comparison to the system dashboard, which is reporting the number of care plans as of December 31st.

value to non-FHT primary care providers who do not have access to inter-professional health provider teams, as this will ultimately benefit patients throughout the KW and surrounding areas.

Cambridge North Dumfries Health Link

The Cambridge/North Dumfries Health Link is awaiting approval of the Readiness Assessment submitted September 2013. In the meantime, the partners have formed a Steering Committee and are establishing a Vision and Values for their future work. As well, the Health Link is planning engagement sessions for partners across sectors from the Cambridge / North Dumfries community to further build support and understanding of the Health Link journey to improve care for residents.

Connect more people with a primary care provider, particularly seniors and individuals with complex issues

Between the start of the Health Care Connect (HCC) program in 2009 and November 2013, the HCC program has connected over 14,000 patients to a primary care provider in Waterloo Wellington. Over the last 6 months, the program has connected over 3,100 residents with a primary care provider, improving our provincial rank from 9th to 3rd.

The program has experienced significant progress in connecting patients. Over the last year; there has been a 50% increase in the proportion of residents registered with HCC without a provider who have been connected with a doctor or nurse-practitioner (7,563 residents connected as of November, 2012, to 14,044 in November, 2013). The program has also experienced strong growth with residents using HCC to find a provider. Between September and November, 2013, there was an average of 415 new registrants with the program per month, which is a 116% increase compared to the first three months of this fiscal year when there was an average of 192 registrants per month.

The success of the program is largely attributed to:

1. WWCCAC's efforts to increase the number of providers who use the HCC program to add new patients to their roster rather than developing their own wait list;
2. Investments in primary care made by the WWLHIN, and;
3. Health Links taking on complex patients regionally.

The HCC program has been focusing efforts on getting more residents without a provider to use the program when looking to find a primary care practitioner. The WWCCAC has undertaken a Community Awareness Campaign to encourage patients without a provider to register with the program. The campaign included: direct mailing, outdoor advertising, local media exposure, community outreach events in August and September, and a community billboard in Kitchener. During October and November of this year following the advertisement campaign, there were 890 new registrants with the program which is 44% higher than during the same months in 2012/13.

Over the past two years, the WWLHIN has funded the expansion of primary care at Guelph Community Health Centre (Guelph CHC), the Waterloo Region NP Led Clinic

and Langs' North Dumfries satellite site. Expansion at Guelph CHC has assisted with attaching complex and vulnerable patients without a primary care provider to a physician or nurse practitioner and developing care plan for complex residents through the Health Links program. At North Dumfries, the expansion has increased the CHC's roster size by 257 patients and decreased wait times for appointments, as well as increased access to same day appointments.

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

The WWCCAC has set-up inter-professional community teams to provide in-home services for people who have complex needs. The Board approved funding for this initiative at their September 2013 meeting. Since that time a great deal of work has been done to begin operationalizing the teams, including hiring of front-line staff and a project team. An orientation session for the teams is planned for January 22nd and the teams will be up and running very quickly after that. The goal of this initiative is to provide wrap-around care plans that integrate family, community, and agency supports and coordinated access to the spectrum of health care providers required to maintain independent living and averting unnecessary use of hospital resources, regardless of the type of primary care provider that a person is connected with.

An essential element of Ontario's health care transformation agenda is the introduction of Quality Improvement Plans (QIPs) to the primary health care sector. Through the QIP, providers express their commitment to a health system that is patient/client centred and illustrate how they will be actively engaged in improving the quality of care residents receive. One of the dimensions that primary care must report on is "timely access to primary care, when needed". All Family Health Teams (FHT) and Community Health Centres (CHC) committed, as part of their QIPs, to ensure that patients have access to a physician or Nurse Practitioner the same or next day, as appropriate.

Expand the Centralized Intake process for diabetes services to the remainder of the WWLHIN

The WWLHIN Central Intake (CI) program, delivered by Langs Community Health Centre (CHC), has earned a reputation for being a provincial leader in developing and implementing a Diabetes CI program. Langs staff provide guidance and share successes with those LHINs who have yet to implement the CI program.

Since 2012/13 year end, there has been over 30% increase in referrals through the Diabetes CI program. This increase puts the program on pace to exceed the year-end target of 4354 patient referrals. Year to date, over 3500 patient referrals have flowed through the Diabetes CI. In addition, there have been 76 self-referrals to the Diabetes CI in 2013/2014, which already exceeds the total self-referrals in 2012/13 (63 self-referrals).

Diabetes program referrals are meeting wait time targets for semi-urgent referrals, however they are falling short of meeting wait time targets for urgent and non-urgent standards. Many programs are incorporating urgent time slots to address the gap in urgent wait times. Also, leadership at Langs has undertaken a review of the CHC

Diabetes Education Programs (DEPs) wait times and performance discussions and action planning are occurring with DEPs not meeting standard wait times.

Automation of the Diabetes CI program is underway. This effort will increase efficiencies between the Central Intake and the DEPs to ensure wait times are being managed to target times. The Diabetes CI program at Langs has continued to expand and is now making inroads into North Wellington. North Wellington also continues to work efficiently through sharing of DEP services at its three Family Health Teams (FHTs) for all local residents of North Wellington, regardless of where they are rostered.

In the most recent Provincial report for key performance measures of the Ontario Diabetes Strategy, the WWLHIN was the top performing LHIN for the important indicator of having all 3 diabetes performance tests (HbA1c, LDL-C, and retinal eye exams) within the corresponding guideline test period. The CI process has positively contributed to the LHINs success in managing diabetes by improving access to care by efficiently referring residents to DEPs and specialists regionally.

Identify opportunities to expand successes in diabetes coordination model to support people with other chronic diseases

A plan to expand successes in diabetes coordination to other chronic diseases is under development. Development of a Chronic Disease Prevention & Management Coordinated Access System (CDPM-CAS) solution to engage primary care providers at the hub of our health system and provide coordinated access to CDPM services for WWLHIN residents living with chronic disease is underway.

An expert panel working group has been created to plan, develop, and implement the CDPM-CAS offering in the WWLHIN. The goal is building awareness and access to services offered in the community while coordinating appointments in a timely manner. Through these mechanisms WWLHIN residents living with chronic diseases will receive the right care at the right time through the creation of a one-stop, simple solution to make it easier for primary care providers to quickly search CDPM (Chronic Disease Prevention & Management) programs which aims to encompass Diabetes, Hypertension (high blood pressure), COPD & Asthma (respiratory diseases), Cardiovascular Disease (heart disease), and Arthritis (pain) services, and related specialists across the LHIN and to make a quick, confident referral to the most appropriate offering for the resident.

A CDPM Physician Lead was recruited to join the WWLHIN. The mandate will be to help develop and implement the CDPM strategy. The CDPM Lead will join the expert panel working group of the CDPM-CAS.

WWLHIN and providers acknowledge that moving forward strategies to address chronic disease will encompass and focus on prevention as a key component of the model; also ensuring that programs are developed with a resident-centered approach customized to the needs of the community.

System-Wide Coordinated Access Project: Related to the CDPM Coordinated Access Project is a system-wide Coordinated Access Project aimed at easy access to

not only CDPM but also diabetes education, community support services, palliative care and other services. EECCAC is coordinating this system effort which is rooted in streamlining referrals and access to care for primary care providers as well as self referral.

Staff have worked with primary care providers to better define the system challenges and opportunities. They have shadowed staff in a primary care office to observe first-hand the challenges in making timely, accurate referrals to care and identified key success factors in potential solutions. The WWCCAC is engaging existing coordinated access providers to develop a solution.

Develop a Centre of Excellence for eHealth

Centre for Family Medicine (CFFM), in partnership with the WWLHIN, has established an eHealth Centre of Excellence (eCE) that is developing and implementing successful, evidence-informed, strategies for eHealth adoption and innovation for Waterloo Wellington. Effective adoption of eHealth amongst health care providers depends largely on how well the technology integrates into clinicians' existing work flow. The eHealth Centre of Excellence is using a clinically focused, academically informed "rapid adoption environment" where front line clinicians will have input into the design and implementation of eHealth tools.

The eHealth Centre of Excellence, through its governance structure (which includes a program council representing Health Service Providers across the continuum), engagement strategy, rapid adoption environment and collaboration with the local technology and education sectors, will lead and influence the provincial, South West Cluster and local eHealth priorities to support the WWLHIN health system change agenda.

ClinicalConnect™ adoption and use is on target. Efforts are focused to increase the use of the clinical viewer amongst solo practitioners and develop sustainability and support to existing users. In particular, integrating more clinical information sources to ClinicalConnect™ like hospital pharmacy data, will give care providers access to more vital information about their client's hospital stay. Further, the eCE is working at standardizing the information in primary care EMRs (electronic medical records) to help improve the quality of information used in clinical decision making. These activities are important to improving quality and safety of care by having the most up to date and correct information.

The Hospital Report Manager project, which enables primary care providers to receive notification and information about their patient's admissions and discharges is delayed. While the technology is available across the province, regional integration to clinical data sources is delayed. The eHealth Physician Lead is working with the cluster LHINs and project team to accelerate the technical work. In the meantime, implementation plans are being developed to roll out immediately when the technology is available in summer 2014.



Creating a More Seamless and Coordinated Healthcare Experience

Integrate Hospice Palliative Care

The Waterloo Wellington Hospice Palliative Care Regional Council is reviewing and revising the integration work plan to take into account the provincial *Declaration of Partnership-Commitment to Action* document. Three priorities in the palliative care integration plan are identified for the next quarter:

- 1) Advanced Care Planning curriculum development: Advanced care planning is a process of reflection and communication - a time to reflect on one's values and wishes, and to let others know future health and personal care preferences in the event that one becomes incapable of consenting to or refusing treatment or other care. Hospice Waterloo Region is leading the development of an educational program for health care providers and residents in order to promote quality of life and continuity of resident centered care.
- 2) Cultural Competency Best Practices (Palliative) for Aboriginal Community: Hospice Waterloo Region, together with the Aboriginal Health and Wellness Program at the Kitchener Downtown Community Health Centre (KDCHC), is working with the aboriginal community to assess the gaps in palliative services, to understand what palliative care means within the aboriginal culture, and make recommendations on a palliative care model for the aboriginal population.
- 3) Increasing services to the Hospice at Home Program—The Hospice at Home Program provides additional nursing and personal support services to support residents who wish to die at home and to reduce the level of ALC attributed to Palliative Care. Service level maximums will be increased.

Acquired Brain Injury System Co-ordination

Acquired Brain Injury Health Service Providers have been working together over the past 2 years to integration services and improve quality and access to care. This effort has resulted in a number of improvements such as specialized care coordination for people with Acquired Brain Injury, enhancements to specialized care in the community, increased knowledge and education of providers across the continuum of care regarding the unique needs of people with ABI, and enhancements to caregiver supports. To

ensure sustainability of ABI system integration efforts, consideration is currently being given to including the ongoing work as part of the WWLHIN Rehabilitative Care Council.

Adult Day Programs

The Adult Day Program (ADP) Network, under the leadership of Region of Waterloo-Sunnyside Home, continues work to identify, refine, and implement best practice care standards for ADP client populations. A project lead has been seconded to accelerate the integration work with specific focus on detailing the recommended service levels and associated policies required to meet client population needs. This work underway includes

- o a review of program cost structures and provide on a common client co-payment fee and alternative funding strategies to resource best practice care.
- o a gap analysis of each ADP provider's ability to meet best practice standards and implementation plan to close the service gaps for each ADP provider.

This initiative is trending yellow since the full roll out is delayed and will occur in FY14/15.

Mental Health and Addictions Integrations

Mental Health Support Coordination

The mental health support coordination committee continues its work to integrate support coordination services into a "cluster" model of care, providing residents with cluster teams comprised of case managers, registered nurse practitioners, peer supports, occupational therapists and psychiatry. It is anticipated that each cluster will support between 100-120 high needs individuals each year with ongoing links to both psychiatric and primary care support.

Canadian Mental Health Association – Waterloo Wellington Dufferin (CMHA-WWD), Grand River Hospital, Homewood Health Centre and Waterloo Regional Homes for Mental Health are in discussions about the ability to provide these services in a coordinated and standardized way, by either establishing agreements among all service or pursuing a voluntary integration of services under one lead provider. It is anticipated that providers will complete recommendations regarding the best model to provide services to residents by February 2014.

Addictions Support Coordination

Addictions Support Coordination providers are developing recommendations regarding improving the model of addictions support coordination in tandem with mental health support coordination to ensure service delivery to those with concurrent needs are built into the design. It is anticipated that support coordinators will be in place and assisting those with substance use issues by March 31, 2014.

Assertive Community Treatment

Homewood Health Centre, Grand River Hospital and Waterloo Regional Homes for Mental Health (WRHMH) have a shared responsibility for the delivery of Assertive Community Treatment (ACT) teams for persons with complex mental health needs. Currently, providers are working on ways to remedy the high wait times for access to this service. An independent review of the integrity of the local program shows a difficulty in “stepping down” current users of ACT services into other community-based care. Providers are working collaboratively on ways to share psychiatric resources and team supports and longer term strategies to improve the quality of ACT team services for residents.

Mental Health and Addictions Coordinated Access Project

Good progress is being made on implementation of the Coordinated Access to Mental Health and Addictions services program. Current staffing will start a comprehensive training program to have all the skills necessary to meet the crisis, intake and referral, screening and assessment needs of residents who will use the anticipated service. Canadian Mental Health Association – Waterloo Wellington Dufferin (CMHA-WWD) as the lead agency continues to meet with service provider partners every two weeks in order to refine the model, support implementation and give updates on progress. In addition, the lead agency is conducting 30+ focus groups with residents, family, and community stakeholders to test the planned implementation model.

As the model creates one “front door” to access local mental health and addiction services, CMHA WWD also has had independent conversations with each Health Service Provider to discuss a transfer of current in-scope resources to the centralized model, while maintaining the integrity of services within each service provider. To date responses from providers have been mixed and options to overcome obstacles are being explored. Despite this, the current model of coordinated access is on target to launch service on April 1, 2014.

WWCCAC and Community Support Service Right Care in the Community

The MOHLTC is developing a policy framework for Home and Community Case Management. Through this process, Home and Community Case Management will ensure that seniors, adults and children receive high quality home and community services when needed to optimize their health outcomes, quality of life and to strengthen health system performance. The Ministry has formed a technical committee on this topic which has three representatives from Waterloo Wellington: Dale Howatt from Community Support Connections, Meals on Wheels and More; Gordon Milak from the WWCCAC and John Ruetz from the WWLHIN. This provincial work is scheduled to be completed in the spring of 2014 and the implementation of policy and legislative changes scheduled to begin in the summer of 2014.

In Waterloo Wellington, the CCAC and the Community Support Services (CSS) collaboration to transition CCAC services towards the higher need population and to transition the lower need population to the CSS sector has been underway since February 2013. While policy and legislative changes are necessary at the provincial level in order to achieve all outcomes from this process, the local CSS sector and WWCCAC have identified a number of process improvements that can be achieved to prepare for the upcoming changes. These process improvements include streamlining

mechanisms of intake and referral to maximize service offerings while minimizing the number of different providers; refining resident assessments to improve the identification of needs and supports to keep residents in their home; and improving technical infrastructures to support improved information exchange.

Despite the rapid start and aggressive local timelines to work through the proposed changes when they were announced in winter 2012/13, this initiative will remain yellow to the end of the fiscal year due to the recasted provincial time lines for implementation. WWLHIN, CSS and WWCCAC are well prepared to implement the provincial changes when they are announced.

Short Stay and Transitional Care

WWLHIN has approved 9 respite beds for the 2014 calendar year located in long term care homes across WWLHIN. This is a continuation of existing respite beds which are reviewed and approved annually. WWLHIN will be monitoring the utilization of these beds and making adjustments to capacity as needed. WWLHIN has also expanded convalescent care capacity from 10 beds to 25 beds with full capacity projected to be available in January 2014.

Behavioural Care

Planning work is underway locally to develop and propose a model of care for providing specialized/intensive behavioral supports in LTC. The Behavioural Supports program is reviewing and updating sustainability plans as well as developing expansion plans to incorporate the new long term care beds recently opened at Hilltop Manor and planned to open at the new long term care facility in Waterloo. Local partnerships have proposed a model for a specialized behavioural unit in LTC for those residents with responsive behaviours that require constant specialized supervision and care. LHIN staff are reviewing this proposal to ensure alignment with the strategy and determine next steps.

Support of the Frail Elderly

The Geriatric Services Network continues its work to advance the action items in the “Developing an integrated system of care for frail seniors in Waterloo Wellington” report in conjunction with the provincial Seniors Strategy. The WWLHIN Rehabilitative Council-Frail Elderly/Medically Complex group is working towards implementing screening tools to quickly assess rehabilitative need/potential under the province’s updated assess and restore policy, as well as referral process redesign to promote intake from community.

A quality improvement initiative is underway aimed at reducing the wait time for access to specialized geriatric services assessment through the use of Nurse Practitioners in the community. The results of this initiative will help inform new program development geared toward moving specialized geriatric services out into the community from the hospital emergency rooms. This will also increase timely access to specialized geriatric services and ensure more effective use the resources available for the frail elderly in our region.

Additional recommendations are being implemented this year, specifically an educational needs assessment to guide training and capacity building in the clinical community; education on privacy and information sharing to improve the communication of resident care information through the health system; and coaching and education on continuous quality improvement within a health care system.



Leading a Quality Healthcare System Using Evidence-based Practice

Develop a Local Quality Partnership

The Local Quality Partnership (LQP) has the purpose of fostering a change management environment using Health System Funding Reform (HSFR) that is focused on attaining quality improvements for local patients and residents. Membership is comprised of a wide cross-section of local Health Service Provider leaders, and is chaired by Dr. Blair Egerdie, Vice-President of Medical Affairs, St. Mary's General Hospital. The work of the group is informed by, and connected with, two provincial tables: Local Partnership Co-Chairs; and the HSFR LHIN Advisory Committee.

The LQP took focused action, as planned, to further expand the membership with a focus on additional clinical leaders, and ensure the group is connected to the work being done to implement the Integrated Health Service Plan across the Waterloo Wellington health care system. While HSFR is important context, the focus of LQP needs to be on quality and care delivery improvements.

The WWLHIN's physician leaders are now regular attendees at LQP, and the forum will be used to make connections across integrated programs, so that successful approaches and initiatives become better known and can be spread across organizations, reducing the risk of duplicative efforts.

Quality Based Procedures

During this fiscal year, the MOHLTC has implemented 10 new Quality Based Procedures (QBP), as part of a multi-year sequenced implementation. The essence of

each QBP is provincial identification of “leading practice” clinical protocols, and the “leading practice price.” Our HSPs are expected to take action to reduce practice variation, improve quality, and ensure its cost structure is in alignment with the leading practice price.

An additional 10 QBPs have been identified for roll out in 2014/15. Our HSPs have this information and should be planning accordingly, including involving the appropriate integrated program councils.

Integrated Program for Stroke Care

Implementation of the regional integrated program for stroke care is on track. Guelph General Hospital (GGH) established a new tPA site as well as acute stroke beds December 1, 2013 and has become a telestroke site. As per the required integration for stroke care, Wellington EMS is directing stroke patients from North Wellington and South Grey to GGH. Patients in Cambridge requiring acute stroke care will be directed to Grand River Hospital (GRH) beginning April 1, 2014. Emergency Medical Services, Integrated Emergency Department Program Council, and rural physicians and hospitals have all been engaged.

Progress continues to be made towards providing care standardized to best-practices. Stroke care pathways have been finalized and are being communicated and implemented.

Improvements have also been made to access for outpatient stroke rehabilitation. GRH Freeport site and SJHC continue to work to improve rehabilitation wait times with both sites now providing access for stroke patients within 7 days, compared to prior wait times of four to six weeks.

New aphasia services have been funded by WWLHIN and St. Joseph's Health Centre (SJHC) is the Sponsor Organization. Services began in early December and will be phased in across five (5) sites within Waterloo Wellington by the end of the fiscal year and will help residents who have had a stroke to continue to recover their ability to speak and communicate once they go home from hospital.

WWCCAC was required by the Stroke Integration Decision to provide a plan to the WWLHIN by November 2013 detailing how they would meet best practice stroke care at home. WWCCAC prepared that plan in consultation with the Rehabilitative Care Council. The plan will not only increase the service levels to best-practice standards but also will use a bundled care delivery model so that the PT, OT, PSW, Nursing etc. for stroke patients will all be provided by the same contracted provider starting in the new fiscal year and these teams will be dedicated to the provision of stroke care, thereby building and sustaining a higher level of expertise.

Comprehensive Rehabilitative Care

The Rehabilitative Care Council continues to move forward its Rehabilitative Care Phase II project. The focus of the Council work streams has been on Integrated Care Paths within the Musculoskeletal, Frail Elderly/ Medically Complex and Cardiopulmonary Streams of Care. Each has identified clinical pathways, and they continue to work

towards developing best practices and based on available evidence. Previously-identified areas of focus are as follows:

Musculoskeletal (MSK)

The Integrated Orthopedic Steering Committee (IOCP) will continue to work on implementation planning for the total joint replacement patient population. The MSK steering committee will likely focus implementation efforts on pre- and post-operative care delivery model and the IOCP committee will be looking at central intake for this patient population. Both committees are working in partnership to develop the care pathway for the entire patient journey to ensure smooth transitions between care settings.

Frail Elderly/ Medically Complex

Focus will be looking at standardizing the referral form/process, communication between providers related to this complex patient population, and wound care protocols. Also, the assess and restore framework is nearing completion.

Cardiopulmonary

Will undertake the development of a standard action plan and common education materials for the COPD pathway. The leads for this project were successful in being accepted to the ministry's Improving and Driving Excellence Across Sectors (IDEAS) training program.

Integrated Clinical Programs:

Addictions and Mental Health

In November, the Core Action Group (CAG) of mental health and addiction providers voted unanimously to dissolve the group in favour of the creation of the Integrated Mental Health and Addictions Program sponsored by Homewood Health Centre. The first meeting of the new program council established goals and actions plans. The Program Council is expected to have enabled and monitored the completion of the following projects by March 31st, 2014:

- Completion of the ACT Team review for service delivery improvement;
- Supportive Housing review to determine best practice, metrics and system improvements going forward;
- An in-depth review and case facilitation of the top 40 repeat visitors to the Emergency Department with either mental health and/or substance use issues;
- Plan for system coordinated psychiatric recruitment;
- Review of current acute system services;
- Concurrent disorder system review to ensure best delivery of service to residents with both mental health and addictions lived experiences;

- Youth Addiction System review to better understand best practices and current service delivery gaps;
- Support Coordination of mental health and addiction services;
- Coordinated Access for mental health and addiction services.

Beyond March 31st, the program council intends to develop programs that better link primary care to existing community and acute services, better understand the role of withdrawal management services in the WWLHIN, better understand the cost comparison of acute services and ensure the delivery of care for those with dual diagnosis (mental health and a co-occurring developmental disability). Homewood Health Centre has taken a lead in developing productive relationships with all mental health and addictions service providers in order to promote collective, resident-centered design of system services.

Cardiac

St. Mary's General Hospital (SMGH) has taken the lead as Sponsor to develop an integrated program for Cardiac Care. The Council is now formed and an inaugural meeting was held on September 27, 2013. SMGH is working with the Cardiac Care Network of Ontario (CCN) to identify leading practices and opportunities for improvement within the WWLHIN. The Cardiac Council met on November 22, 2013 when CCN discussed their new road map for cardiac services in Ontario, which SMGH is planning to use to guide future development of cardiac services in the WWLHIN. The next steps for the Council, with the LHIN, is to develop the current state and to identify gaps and opportunities, and to set priorities for the coming year.

Critical Care

The WWLHIN continues working with the Waterloo Wellington Critical Care Network to identify leading practice, to evaluate the current practice of hospitals and to identify areas of practice variation and to develop plans for improvement. The Critical Care Secretariat's ICU High Performing Checklist has been identified as leading practice and all hospitals have conducted a self-assessment audit comparing current practice to leading practice and identifying gaps. Hospitals are at varying stages of implementing the leading practice and the WWCCN will be developing plans over the next few months to further close the remaining gaps. They have been working on a current state analysis of hospital ICU services compared to Critical Care Ontario's ICU high performing checklist.

Emergency

The Emergency Services Council continues its work on early initiatives for system-wide implementation, focusing on: single standards of care, spreading identified best-practices, and building capacity for sustainable quality improvement. Further, as Sponsor Organization, Guelph General Hospital is working on an application to participate in the ministry led IDEAS training program, with a focus on enabling best-practice in ED triage

Pharmacy

The integrated clinical program for pharmacy continues its work in antimicrobial stewardship as an early opportunity for system-wide quality improvement, consistent with the new requirements from Accreditation Canada.

Surgery

The Orthopedic Steering Committee met on December 3rd, 2013 continues to advance the recommendations as set out in the comprehensive improvement plan for orthopedics.

Implement an integrated wound management program

The first meeting of the Wound Care Council took place on January 15th, 2014 where council members conducted a review of the project scope, terms of reference and discussed the initial work plan. A sub-committee made of Council members was struck to review the submitted consultant proposals for Phase I, with the goal of selecting a firm by the end of January 2014. It is expected that by March 24th 2014, the consultant will have completed all contracted work, including a current state analysis of wound care, the development of a future state model for integrated wound care services, and the development of implementation and sustainability plans; so that Phase II (Implementation) can begin in 2014/15.

Implement the Provincial Life or Limb policy

The Life or Limb Policy embraces a philosophy of care for our sickest, most vulnerable critically ill patients, and promotes the patient's clinical condition as priority. The perception of life or limb conditions is predicated on the clinical services available at a referring hospital to manage these cases - and for some hospitals in Ontario, these clinical services may be limited. Therefore, the provincial Life or Limb Policy aims to ensure that appropriate and timely acute care services are available to patients who are life or limb threatened. No patient with a life or limb threatening condition will be refused care.

Hospitals have been notified of their new obligations under the Life or Limb policy. The policy is now in effect. Critical is tracking data related to the successful transfer of life or limb patients and reporting will be provided to LHINs and providers to allow for continuous improvement of the system of care.

Meeting Standards set both by the Province and Locally

Knee Replacement

The Orthopaedic Steering committee has engaged clinicians and recognized provincial experts in developing a comprehensive improvement plan for orthopaedics which includes eleven recommendations that are being implemented across all hospitals.

As a system, WWLHIN has wait times above the 166 day target. While GRH and GGH have wait times much better than target, high wait times of one surgeon at CMH are pulling wait times at the system level above target. This high wait surgeon effectively reduced WWLHIN's performance from 99% of cases meeting target to 74% of cases meeting target. WWLHIN staff met with CMH on November 22 regarding this high-wait surgeon and had a productive discussion. The hospital, including the Chief of Surgery, are working with this surgeon to align the waitlist management approach in ways conducive to improving wait times. Since that time, the wait list for this surgeon has not increased, although 280 patients continue to await care. WWLHIN staff are taking follow-up action with CMH.

A joint IDEAS project that includes GGH and WWLHIN staff and focuses on the development of a central intake model at GGH is underway. Communication between this team and the System Coordinated Access project team is ongoing in order to align these projects as they develop.

The WWLHIN has engaged hospitals about coding practices. An analysis of open wait lists shows that surgeons at GGH have altered their coding practices to use the Priority IV designation, as appropriate. Should wait time performance remain consistent with current results at GGH, the change in coding practice will improve the WWLHIN result on the "Percent of Priority IV Cases Completed within Access Target" indicator.

The WWLHIN made a one-time investment of 27 knee replacements (\$214,000) in December 2013; CMH, GGH and GRH each received funding for 9 additional knee replacement surgeries. Additional capacity exists for further investment should funds become available for this purpose.

Diagnostic MRI

Data for November 2013 shows that wait times are above the target of 28 days but is still better than the same time last year. The WWLHIN was successful in efforts to obtain additional funding for Waterloo Wellington to address waiting lists. \$259,000 has been allocated to CMH, GGH, and GRH for additional MRI services to be provided to residents by March 31, 2014.

The MRI & CT Wait Times Committee has committed to improving access to MRI services for all patients, particularly for more urgent cases (Priority 2 and 3). As such, the change in MLPA metric reveals that the system is challenged to complete Priority 4 cases within target. The WWLHIN has continued dialogue with the chair of the WWLHIN MRI & CT Wait Times Committee on potential engagement of the University Health Network's process improvement team to improve processes should additional funds become available.

The WWLHIN continues to participate in the MRI process improvement project and in challenging the MRI & CT Wait Times Committee to improve operational efficiencies and to utilize all system capacity. Further, a WWLHIN staff member will participate on the newly-formed Access to Care Diagnostic Imaging Advisory Committee as a LHIN representative. The first meeting of this committee is scheduled in February.

ER Length of Stay – Admitted and Non-Admitted

Guelph General Hospital (GGH) has been identified as the program Sponsor Organization for the Integrated ED Clinical Program. A program council comprised of actively engaged ED physicians and clinical leaders from across Waterloo Wellington has been formed. The WWLHIN has recruited a regional clinical lead for ED (Dr. Ian Digby, Chief at GGH) who co-chairs this council.

As a system, the WWLHIN continues to have the best ED admitted lengths of stay in Ontario - for 10th consecutive months now. At 14.1 hours, WWLHIN results in November 2013 are 13.5 hours better than the provincial average.

Although more work needs to be done, the achievements related to the ED length of stay for admitted patients have been recognized at the provincial level. On January 23rd, Dr. Ian Digby and WWLHIN staff will present on WWLHIN initiatives to improve patient flow across the system, including in the ED, at the ED LHIN Leads meeting in Toronto.

APPENDIX B:
Action Plans – Initiatives
Update

ACTION PLANS						
Enhancing Your Access to Primary Care	2013/14		2014-2015		2015-2016	
	Progress	% Complete	Progress	% Complete	Progress	% Complete
Ensure individualized, coordinated care plans for those who access health care the most through Health Links across Waterloo Wellington	In Progress	10	In Progress	50	In Progress	80
Build linkages between health, social services, justice, and other community partners	In Progress	50	In Progress	75	In Progress	100
Improve health equity through remote access to care close to home.	In Progress	25	In Progress	50	In Progress	75
Improve access to best practice diabetes care and chronic disease prevention and management through easy access to programs, and implementing best-practice guidelines.	In Progress	50	In Progress	75	In Progress	90
Implement enabling technologies including Ontario Laboratory Information System (OLIS), Hospital Report Manager (HRM), and technology supporting Health Links and coordinated access	In Progress	60	In Progress	90	In Progress	100

Creating a More Seamless and Coordinated Healthcare Experience	2014-2015		2015-2016		2016-2017	
	Progress	% Complete	Progress	% Complete	Progress	% Complete
Improve access to care through streamlined, coordinated access to services, starting with: ▪ Improving and enhancing existing coordinated access services Diabetes, Chronic Disease Prevention and Management, Mental Health and Addictions, Specialized Geriatric Services, Rehabilitation, CSS ▪ Expanding coordinated access to additional service areas ▪ Ensuring knowledge and use of coordinated access services by the community and professionals.	In Progress	75	In Progress	100		
Strengthen and maximize the current capacity of community services.	In Progress	50	In Progress	70	In Progress	90
Remove barriers for people waiting for an Alternate Level of Care	In Progress	50	In Progress	75	In Progress	100
Design services based on what people need and say is important to them at both the system (LHIN) and Health Service Provider level. All Health Service Providers will begin to measure and report on how they are improving the resident's experience	In Progress	25	In Progress	50	In Progress	75
Support at-risk seniors through local implementation of the Assess & Restore policy	In Progress	25	In Progress	75	In Progress	100
Improve the quality and safety of care in Long Term Care Homes	In Progress	50	In Progress	100		

Leading a Quality Healthcare System using Evidence-Based Practice		2013/14		2014-2015		2015-2016	
		Progress	% Complete	Progress	% Complete	Progress	% Complete
Improve patient outcomes through the delivery of best-practice care, at the best practice price, in alignment with the implementation of the 2014-2015 Quality Based Procedures provincial slate.		In Progress	50	In Progress	75	In Progress	100
Create <u>integrated programs</u> across the health system to a continuum of services for specific patient populations that offer the same standard of high quality wherever a particular service is provided, and access based on best practice.		In Progress	50	In Progress	75	In Progress	100
Existing integrated programs will develop and implement strategies that will transform the quality of care and experience for WWLHIN residents.							
	Integrated Hospice Palliative Care: - Standardize admission criteria to system resources including residential hospice to streamline access to care - Improve service delivery model to support clients at home	In Progress	100				
	Rehabilitative Care Improved quality of care, and reduced variation in practice and outcomes through the implementation of a series of new standardized patient pathways across sites that will streamline the patient journey based on needs	In Progress	75	In Progress	100		
	Mental Health and Addictions - Develop and implement mental health & addictions service improvements based on the experience of high needs residents. - Develop and improve access to more	In Progress	50	In Progress	75	In Progress	100

	effective youth addictions services. Develop and improve access to more effective mental health services and supports for youth and young adults.						
	Emergency Department - Improved patient access through ongoing identification and ‘spread’ of best-practices in patient ‘flow’ – within the ED, the hospital and beyond. - Improved patient outcomes through standardized care pathways (beginning with asthma & influenza). - Improved patient and provider experience through the implementation of identified best-practices for patient triage	In Progress	50	In Progress	75	In Progress	100
	Cardiac Accelerate quality improvements in cardiac care through the establishment of a system plan for WWLHIN in alignment with the Cardiac Care Network’s provincial strategies	In Progress	50	In Progress	75	In Progress	100
	Surgery - Improve patient access and outcomes through the implementation of select recommendations from the Integrated Orthopedic Steering Committee, including an <i>integrated access system</i> for orthopedic care - Implement of the Waterloo Wellington Vision Plan including assessment and recommendations regarding possible community based specialty programs	In Progress	50	In Progress	75	In Progress	100
	Critical Care Monitor and improve upon implementation of the provincial Life or Limb policy that will ensure the transfer of critically ill	In Progress	80	In Progress	100		

	patients to the closest, most appropriate care institution Improved care quality and outcomes by the implementation of the critical care High Performing Checklist						
Implement new integrated 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: - Integrated Diagnostic Imaging Program - Integrated Wound Program		In Progress	50	In Progress	75	In Progress	100

APPENDIX C:

Performance Targets and Results

OUR PRIORITY: Leading a Quality Healthcare System Using Evidence-based Practice



Annual Plan Initiatives

- ▲ **Improve patient outcomes through the delivery of best practice care, at the best practice price, in alignment with province-wide Quality Based Procedures**
 - **Implement new integrated 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:**
 - ▼ Integrated Diagnostic Imaging Program
 - ▲ Integrated Wound Program
 - **Expand and enhance integrated programs that ensure quality and deliver best practice care across the continuum of care. Key improvements will include:**
 - ▲ **Cardiac:**
 - ▲ Identify and implement improvements including remote pace-maker monitoring trial
 - **Critical Care:**
 - ▲ Implement the provincial life or limb policy across Waterloo Wellington
 - Implement critical care High Performing Checklist
 - ▲ **Emergency Department:**
 - ▲ Implement best practices across the continuum of care to meet emergency department wait times
 - ▲ Implement standardized care pathways (beginning with asthma & influenza)
 - Implement best practices for patient triage
 - **Hospice Palliative Care:**
 - Improve admission process
 - Improve service delivery model to support clients at home
 - **Mental Health and Addictions:**
 - Develop and implement service improvements based on the experience of high needs residents
 - Improve youth addictions services
 - Improve access to more effective mental health services for youth and young adults
 - ▲ **Rehabilitative Care:**
 - ▲ Implement standardized patient pathways across sites
 - ▲ **Surgery:**
 - Design and implement an integrated access system for orthopedic surgery
 - ▲ Develop and implement the Waterloo Wellington Vision Plan including possible community-based specialty clinics

Annual Plan Performance Outcome		Most Recent Performance						Target	LHIN Rank	Most Recent Reporting Period	
		Cambridge, North Dumfries	Kitchener, Waterloo, Woolwich, Wellsley, Willmot		Guelph Area	Rural Wellington Area					Aggregate WW System Performance
		Cambridge Memorial Hospital	Grand River Hospital	St. Mary's General Hospital	Guelph General Hospital	Groves Memorial Community Hospital	North Wellington Health Care				
➤	Residents will obtain non-urgent MRIs within the 4 weeks	67.4%	9.2%	-	58.7%	-	-	45.1%	90.0%	6	Q1 2014-15
➤	Residents will obtain non-urgent CT scans within 4 weeks	94.6%	46.9%	47.5%	96.5%	96.6%	-	73.6%	90.0%	11	Q1 2014-15
➡	Residents will receive non-urgent Cardiac By-pass Surgery within 90 days	-	-	100.0%	-	-	-	100.0%	90.0%	1	Q3 2013-14
➡	Residents with a life or limb threatening condition will be transferred to an appropriate facility within 4 hours or less	100.0%	77.8%	-	100.0%	-	-	94.0%	90.0%	N/A	Q4 2013-14
➤	Patients requiring admission from the emergency department will be transferred to a hospital bed in 8 hours or less	17.3	19.8	17.3	13.7	16.2	-	17.3	8.0	1	Q4 2013-14
➤	Patients with complex needs requiring care in an emergency department will be seen and sent home in 7 hours or less	6.9	7.5	6.2	5.6	6.0	-	6.6	7.0	6	Q4 2013-14
➤	Patients with minor, uncomplicated needs requiring care in an emergency department will be seen and sent home in 4 hours or less	4.1	5.6	4.2	3.9	3.4	-	4.3	4.0	10	Q4 2013-14
➡	Residents will have the ability to die at home or within a community setting rather than in hospital	↓ 14.1%	↓ 9.9%	↑ 10.5%	↑ 45.8%	↓ 20.5%	↓ 38.9%	↓ 0.8%	↓ 10.0%	8	Q4 2013-14
➤	Fewer residents will have repeat visits to the emergency department for Mental Health Conditions	15.3%	18.3%	14.5%	11.5%	5.5%	18.4%	15.0%	13.2%	3	Q3 2013-14
➤	Fewer residents will have repeat visits to the emergency department for Substance Abuse	16.0%	22.9%	13.9%	18.6%	0.0%	-	20.0%	18.1%	2	Q3 2013-14
➤	Residents will receive non-urgent hip replacements within 26 weeks	60.7%	100.0%	-	97.6%	-	-	87.0%	90.0%	5	Q1 2014-15
➤	Residents will receive non-urgent knee replacements within 26 weeks	46.0%	100.0%	-	97.8%	-	-	78.9%	90.0%	8	Q1 2014-15
➤	Residents will receive non-urgent cancer surgery within 12 weeks	100.0%	95.7%	100.0%	88.9%	-	-	98.1%	90.0%	3	Q1 2014-15
➤	Residents will receive non-urgent cataract surgery within 26 weeks	86.0%	-	99.8%	98.6%	-	-	96.4%	90.0%	5	Q1 2014-15

Waterloo Wellington LHIN

Quarterly Performance

For more information, please contact the WWLHIN at waterloowellington@lhins.on.ca

LEGEND

INITIATIVES

- ▲ Initiative is complete or on track with implementation plan
- Initiative is at risk for achievement within implementation timeline
- ▼ Issue exists. High risk for not implementing in timeline

PERFORMANCE

- Meets or exceeds target
- Does not meet target but has improved from baseline
- Does not meet target and has not improved from baseline



Better Health - Better Futures

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